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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

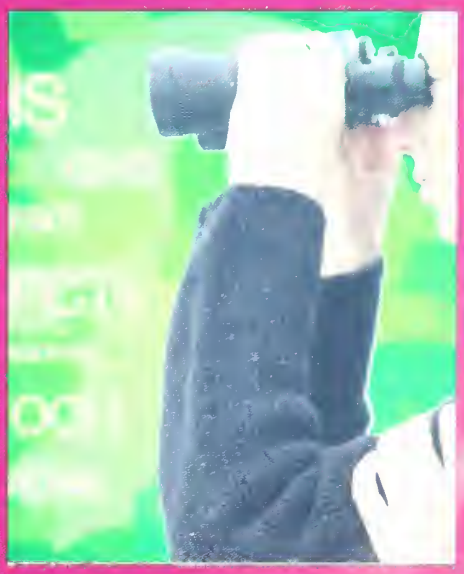
23 July 2005

October cut off for new style ESPS service

IT experts debate e-script fears for the high street

Tesco gets all its pharmacists MUR accredited

Looking out for the impact of commissioning



New range available from your local wholesaler.

Back Pain Heat Patches (PIP 308-6139); Nurofen Back Pain SR Capsules 12s (PIP 308-6113) & 24s (PIP 308-6121).

Nurofen Back Pain SR Capsules: capsules of 300mg ibuprofen in sustained release granules. **Indications:** Backache, rheumatic pain, muscular pains. **Dosage:** Short-term oral use. Adults and children over 12 years: One or two capsules, twice daily. Not more than 4 capsules in 24 hours with at least 8 hours between doses. If required for more than 10 days, or if symptoms worsen, consult a doctor. **Contraindications:** Known hypersensitivity to ibuprofen or other ingredients. History of bronchospasm, asthma, rhinitis, or urticaria, associated with aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). History of, or existing gastrointestinal ulceration/perforation or bleeding, including that associated with NSAIDs. Severe hepatic failure, severe renal failure or severe heart failure. Concomitant NSAIDs, including COX-2 inhibitors. Last trimester of pregnancy. **Special warnings and precautions for use:** SLE and mixed connective tissue disease. Gastrointestinal disorders and chronic inflammatory intestinal disease. Hypertension and/or cardiac impairment. Renal impairment. Hepatic dysfunction. Bronchial asthma or allergic disease. GI bleeding, ulceration or perforation, which can be fatal has been reported with all NSAIDs at anytime during treatment, with or without warning symptoms or a previous history of GI events. Caution with concomitant medications which could increase the risk of gastrotoxicity or bleeding, such as corticosteroids, or anticoagulants such as warfarin or anti-platelet agents such as aspirin. Withdraw treatment if GI bleeding or ulceration occurs. Possible reversible effects on fertility. **Side effects:** Hypersensitivity reactions including (a) non-specific allergic reactions and anaphylaxis, (b) respiratory tract reactivity e.g. asthma, aggravated asthma, bronchospasm, dyspnoea, (c) various skin reactions e.g. pruritus, urticaria, angiodema and more rarely exfoliative and bullous dermatoses (including epidermal necrolysis and erythema multiforme). **Gastrointestinal disturbance including:** peptic ulcer, perforation or GI haemorrhage, headache, acute renal failure, liver disorders, haematopoietic disorders including anaemia. **Product licence Number:** PL 0327/0101 **Licence Holder:** Crookes Healthcare Limited, Nottingham NG2 3AA. **Legal category:** P. **Price** (MRRP): 12s (£3.04) 24s (£5.65) **Date:** July 2005

www.dotpharmacy.com

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October cut-off for revised ESPS

by Adrienne de Mont

New arrangements under the Essential Small Pharmacies Scheme will apply from April 1, 2006 in England.

Contractors wishing to be included in the new scheme must inform their primary care trust by September 30 and complete a formal application by October 31, 2005.

The scheme guarantees a minimum income for pharmacies with low volume dispensing. In 2006-07, existing ESPS pharmacies dispensing at least 6,000 and fewer than 26,400 items a year, and which are more than 1km (on foot by the nearest practicable route) from the next pharmacy, will have the following options:

- To convert as a right to a local pharmaceutical services (LPS) contract specifically for essential small pharmacies (ESPLPS) and receive a fixed remuneration;
- With the PCT's agreement, convert to a standard LPS contract;
- Return to the national community pharmacy contractual framework (PhS) and not qualify for any additional support, as the ESPS will cease under PhS.

ESPLPS pharmacies will receive a set monthly payment of £4,078 in 2005-06. The rate for 2006-07 will be notified later. Reimbursement of items dispensed will be on the same basis as for PhS contractors.

An ESPLPS contract will initially be for a fixed term of five years. The pharmacy will be required to provide all essential services under PhS. It will be expected to open 40 hours a week, like other pharmacies, unless the PCT agrees fewer hours. Pharmacies opening 35 to 40 hours will receive the full ESPLPS payment, while those opening fewer than 35 hours will receive a proportion.

PCT and contractor may agree reduced hours to allow the pharmacist to undertake other duties when the pharmacy is closed.

Funding for the additional service would come from the PCT's unified budget.

Details are being sent to existing ESPS contractors in a letter signed by the DoH, PSNC and NHS Employers.

The signatories believe that PCTs will have the necessary flexibility to meet future local health needs through a combination of the PhS framework and LPS, so the ESPLPS scheme will be closed to new applications after October 31. Pharmacies expecting to meet the required criteria before March 31, 2006, must apply to join ESPS before October 31.

PCTs will be asked to review all ESPS pharmacies dispensing fewer than 6,000 items in the previous year.

If the PCT certifies the pharmacy as necessary for proper provision of pharmaceutical services, the pharmacy may join ESPLPS.

Otherwise it may be offered a standard LPS, or continue as a PhS pharmacy outside ESPLPS and receive payments for 12 months. The current ESPS scheme in Wales will continue in its current form.

MEDICINES

Amorolfine seeks P switch

Galderma has applied to the UK drug regulator for a POM to P switch for Loceryl Nail Lacquer (amorolfine).

The company has applied for an OTC licence for the preparation, to be known as Curanail Lacquer, for the treatment of fungal nail infections. Although the product has only been available on prescription in the UK since 1991, Galderma says the antifungal is already available over the counter "in some countries".

Curanail sales would be limited to those aged over 18 years with mild infections in a maximum of two nails, and contraindicated in specific patient groups such as pregnant or breast-feeding women and diabetics.

The manufacturer says it will supply training materials to pharmacists to aid diagnosis and safety and resistance would not be affected.

Comments should be submitted to Amanda Lawrence, DoH, MHRA, Room 14-110 Market Towers, 1 Nine Elms Lane, London SW8 5NQ or e-mailed to *Amanda.Lawrence@mhra.gsi.gov.uk* by August 30.

Further information is available at *www.medicines.mhra.gov.uk/inforesources/publications/ARM31.pdf*

ETP will not threaten 'bricks and mortar' community pharmacies

The rollout of electronic transmission of prescriptions (ETP) will not threaten the future of pharmacists' businesses, IT experts have said.

Their comments came after Richard Granger, NHS Connecting for Health chief executive, predicted the introduction of ETP would lead to the demise of "bricks and mortar" pharmacies at the expense of "virtual" rivals, according to a report by internet newsletter *E-Health Insider*.

Mr Granger indicated at a Health and Social Care Exchange conference that pharmacies faced the same fate as many sub-post offices, which closed after the introduction of electronic payments. However, Ian Shepherd, partner at IT advisor Synapse Consulting, stressed that Mr Granger's conclusions were misplaced, adding: "Pharmacies do not work on the same principle as the Post Office. They will remain more popular than web services because operators provide the public with rapid access to a healthcare professional on the high street."

Ewan Davies, chairman of the Primary Healthcare Specialist Group of the British Computer Society, dismissed Mr Granger's comments as "hyperbole". He said: "I don't think that pessimistic model is borne out by the evidence. The percentage of the market likely to go to mail order is small. If you look at the US model, internet orders have reached a ceiling of 15 to 20 per cent of total business."

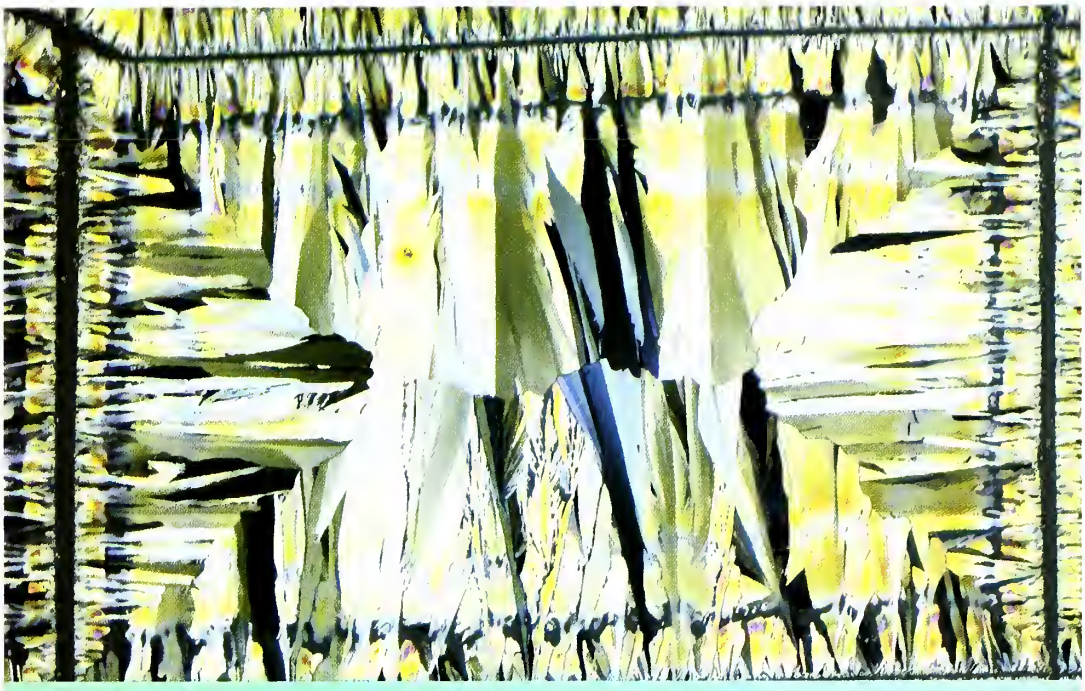
Mr Granger also claimed that current GP systems suppliers would be vastly reduced by 2010, as operators were running on an "unsustainable" business model, according to *E-Health Insider*.

Ian Shepherd: 'bricks and mortar' pharmacies will remain more popular than web services

However, in a confidential letter to systems suppliers, Mr Granger is believed to have sought to repair relations. It is understood he claimed not to have made the remarks and that consolidation in the market would only be due to the large number of system suppliers. NHS Connecting for Health was unable to confirm or deny the accuracy of comments attributed to Mr Granger.

It responded: "The NHS IT programme presents significant new opportunities for community pharmacists, making information available electronically. Even the first implementations of the electronic prescriptions service have shown some immediate benefits in terms of the elimination of data entry from prescription forms. All pharmacists will be able to benefit from the new service as it rolls out. The electronic prescriptions service will free up time for pharmacists, enabling them to develop and offer new services as part of the new contract framework for community pharmacy."

MG



MULTIPLES

Tesco ready for MURs

Tesco is to start conducting medicines use reviews in all 200 branches, following the accreditation of all 395 of its pharmacists.

Tesco staff completed the *C&D*/Medway School of Pharmacy *Skills for the Future* course, supported by in-house CPD training courses and 60 hours' of funded CPD training time.

Tesco has set up a paper-based system to review patients on long-term medication. According to superintendent pharmacist Penny Beck, the chain is deciding which long-term medication patients to review, although it remains open to suggestions from primary care organisations. It is also working on an IT-based link between the MUR and patients' dispensary records.

So far, the company has evaluated only the accreditation process, and says that its pharmacists found the shared learning time and funded time off useful. "Pharmacists now understand that an MUR is actually only about talking to patients about their medicines," said Ms Beck.

Tesco is also planning to use consulting rooms for services such as smoking cessation, healthy living, dietary advice and is waiting for primary care organisations to decide how they will roll out services. Mostly, they have completed their pharmaceutical needs assessments, she said. At the moment, Tesco is funding any necessary training, pharmacy training manager Karen Marsden said, although this is considered a "needs-must" situation.

As well as being a funding stream, Tesco believes that MURs are a vital element of the new contract. "The Government has recognised that pharmacists are an underutilised resource and that by developing pharmacists' skills, everyone benefits," said Ms Beck. **AC**

MULTIPLES

Lloydspharmacy gains people power award

Lloydspharmacy has received the Investor In People (IIP) accreditation, which recognises an organisation's improving performance through its workforce.

IIP inspectors praised the group for its "professionalism throughout the organisation" and a "commitment by management to develop employees".

The award, which covers 1,400 branches, followed a two-month project with Lloydspharmacy employees by the IIP team.

Director of training and development at Lloydspharmacy Steve Howard said: "People are the crux of any good business and we are absolutely delighted that our efficient staff and systems have been recognised in this way."

Inbrief

US acquisition

Pharmaceutical manufacturer Novartis has completed the £375 million acquisition of Bristol-Myers Squibb's US over the counter medicines business.

The deal provides the Swiss based firm with drugs including headache pill Excedrin, which had a turnover of $258m in the US in 2004.

GSK lines go ZD

The Department of Health has confirmed that 30 products made by GlaxoSmithKline have been added to Part II of the *Drug Tariff* (zero discount lists). Available at *www.psnc.org.uk*, the lines include Avandamet tablets, Zantac 75 preparations and Septrin products.

Report on PILs

A report on patient information leaflets has been launched by the Medicines and Healthcare products Regulatory Agency in response to concerns about their failure to meet the needs of patients. *Always Read the leaflet – Getting the best information with every medicine*, aims to address risk communication and allow patients to manage their medicines better.

Age measures

The Department of Trade and Industry has announced measures to prevent discrimination against over 65s in the workplace.

The rules cover recruitment, promotion or training of staff. The legislation will outlaw forced retirement at ages below 65 without proper reason and remove the current age limit for unfair dismissal and redundancy rights, according to the DTI.

The proposed regulations will become law in October 2006 if approved by Parliament.

Cialis case

Ashish Halai of Borehamwood, Hertfordshire, has been remanded on bail after being charged with offences relating to the illegal sale and supply of Cialis and Viagra.

Appearing at South Western Magistrates Court on July 15, Mr Halai was charged with two offences under the *Trades Mark Act 1994* and four under the *Medicines Act 1968*.

The case is unconnected to the MHRA's ongoing investigation into counterfeit Cialis in the legitimate supply chain.

Welsh Assembly defends free prescriptions

The Welsh Assembly has played down claims that its policy of free prescriptions will play havoc with NHS budgets.

The price of a prescription will drop by another £1 next April to only £3, compared with £6.50 in England, before falling to zero by the time of the 2007 election.

While prescription tourism from England will be abolished – Welsh pharmacists from next month will charge the lower rate only to customers using a bilingual Welsh form – voices in the industry fear that the 22 Welsh local health boards will suffer in other ways.

Both Liberal Democrats and Conservatives oppose the move to free scripts, arguing that the money could be better used.

Challenging the latest reduction, Jenny Randerson, Liberal Democrat, said: "The medicines budgets of LHBs are seriously stretched, and there is pressure on them to be reduced again. There was only a 2 per cent increase this year in their medicines budgets, compared with a recommended increase of 9 per cent in England.

"It is obvious that the cheaper prescriptions become, the higher the demand for them will be – that is the simple law of supply and demand. LHBs are not in a position to finance the higher demand, and it is important, in order to keep within budget, that they do not start cutting back on the prescription of more unusual or expensive medicines."

Conservative health spokesman Jonathan Morgan said: "Many opposition members believe that free prescription charges will not be an acceptable use of taxpayers' money. I do not believe that the Assembly Government has accurately assessed the cost of delivering free prescriptions."

Health minister Brian Gibbons told AMs of the considerable advantage delivered by free prescriptions, adding: "We have a bigger burden of chronic illness in Wales; the merits of this policy will become more self-evident." His office later admitted that although LHB budgets were currently "very tight", this policy to offer free prescriptions was a "long-term investment in the health of Welsh patients". **CB**

Medicines Partnership to collaborate with NPC

The Medicines Partnership is to join forces with the National Prescribing Centre from April next year. The Department of Health is providing £0.5m to support the transition. The Medicines Partnership will be repositioned within the framework of the NPC and will no longer receive significant core central funding from the DoH, but will be expected to be self-funding through marketing its services to NHS organisations.

Health minister Jane Kennedy announced the news as she addressed the first learning workshop of the Community Pharmacy Framework Collaborative on Tuesday. Ms Kennedy added that the Medicines Partnership will also be providing new support material for pharmacists conducting medicines use reviews (MUR).

Training courses to give pharmacists the skills for effective MUR will be developed by the Medicines Partnership in collaboration with the NPC, which will produce a booklet to help patients understand MUR.

In one of her first speeches as minister with responsibility for pharmacy, Ms Kennedy highlighted the importance of pharmacy which she said was "increasingly recognised" as an essential part of primary care. "In the past the NHS has not made use of pharmacists' full potential. Their knowledge has gone underused."

Ms Kennedy also spoke of rapid progress made by pharmacists and PCTs since the new pharmacy contract was introduced. Between March and May the number of items dispensed under the repeat dispensing arrangements jumped by a quarter, while by the end of May, 120 pharmacies had conducted 1,200 MURs. **AG**

MEDICINES

Amlodipine costs £16m in profits

Pharmacists' profits fell £16 million between June and July on the back of Government efforts to recover profits on purchases via its category M mechanism.

Between June and July, average pharmacy profitability fell from £48m to £32m, following Government efforts to recalculate category M prices after the removal of amlodipine in the first quarter of the year. Since April, when category M was introduced, average total pharmacy profitability has fallen from just under £50m to its current level of £30m, data from analyst Wavedata reveals.

In July 2003, average total pharmacy profitability was £60m, according to its comparison of *Drug Tariff* prices and average ex-wholesaler or ex-manufacturer prices. The main slumps in profitability have been felt around January and September 2004, when the Government cut the prices of doxazosin, lisinopril, simvastatin and omeprazole.

Accepting that the substantial price changes in the July *Drug Tariff* came as a result of the decision to remove amlodipine from category M in the first quarter of the year, PSNC says it has been working on monitoring arrangements to ensure delivery of new contract funding. **AC**

Corrections

Business information group VNU has acquired data provider IMS Healthcare in a £4 billion deal, not the £4 million figure reported in *C&D, July 16, p10*. Also, the two companies have combined revenue of over £3 billion rather than the £3 million figure reported.

In a separate story, the DoH has allocated £2.1m for the Community Pharmacy Framework Collaborative and not £4m, as reported in last week's *C&D, July 16, p12*.

Questiontime

This week's question:
Will ETP be beneficial for community pharmacies in the long term?

Yes No Don't know

You have until noon on July 26 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on July 30.

Quadrant Pharmacy, St Albans

sue hyde

Boots the Chemists, Buckingham

sukaina manjs

cheryl bagley

nda alexander

Lloyds Pharmacy, Newtongrange

jill welch

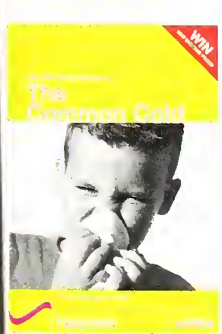
Morrisons, Solihull

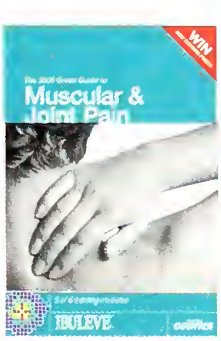
jenny mannings

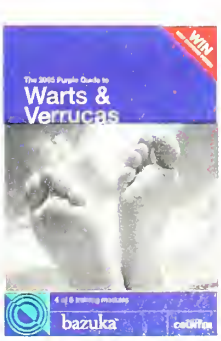
Rowlands Pharmacy, Walsall

Congratulations to the winners of our Happinose IBULEVE 4head bazuka Otex and Freederm competitions, featured in the Pharmacy assistants training modules.

If you've missed any of the guides, call your Dendron representative on 01923 229 251.







Another bright idea from Diomed.

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LEGISLATION

DoH amends pharmacy regs to close loophole

by Gary Paragpuri

A loophole allowing a pharmacy awarded a contract in an exempted shopping centre to then relocate outside the centre has been closed by the DoH.

Under the control of entry regulations introduced earlier this year, pharmacists who applied for a contract in a shopping centre over 15,000sq m could subsequently seek automatic approval to relocate outside the shopping centre.

But amended regulations that came into force on July 5 have closed this loophole. Other changes in the amended regulations will:

- Enable pharmacists to dispense prescriptions written by suitably qualified optometrists.
- Allow the exemption for pharmacies in one-stop primary care centres to apply even if there is a group of primary care medical services contractors who come together on the site but do not formally merge their practices.
- Clarify the regulations regarding services in rural areas so that an application by dispensing doctors to dispense will be refused wherever the premises are within 1.6km of a pharmacy. This will not prevent doctors from moving existing dispensing premises.
- Enable PCTs to suspend contractors more quickly if needed, eg if there is a risk to public safety.

For more information:
www.dh.gov.uk

SCOTLAND

Cegedim is first to launch e-MAS

Cegedim Rx has become the first IT system supplier to provide full electronic support for Scotland's new electronic minor ailments service (MAS).

E-MAS kicked off in Scotland on July 13, taking Scotland's minor ailments service provision into the electronic age. To support the new service, Cegedim Rx has added e-MAS functionality to its Pharmacy Manager PMR system, enabling Scottish contractors to electronically check a patient's MAS registration status and transfer information about the consultation and any medicines prescribed from the pharmacy's PMR system to the e-MAS support central store.

In future the messaging system will also be used for remuneration.

Toll Pharmacy in Prestwick, Ayrshire, was the first pharmacy to use the e-MAS service. Proprietor Cathy Burns believes e-MAS is an invaluable addition to Scotland's pharmacy services. "Minor ailment service patients tend to be quite demanding," she said. E-MAS has streamlined the whole process of caring for them." She also commended Pharmacy Manager e-MAS's functionality for its speed and ease of use.

Steve Marriott, Cegedim Rx marketing manager, said: "The successful implementation of e-MAS is a historic development for pharmacy in Scotland. Helping our customers to be the first pharmacies to participate is a fantastic achievement." **AC**

Gautam Patel, pictured with BPSA president Hemant Patel, has been elected as president of the British Pharmaceutical Students Association. Mr Patel, who has been assistant general secretary since 2003, took over from Tamara Wood on Saturday

PCT LINKS

Nearly all PCTs are geared up for the new contact

Nearly 90 per cent of primary care organisations had done some preparation for the new pharmacy contract ahead of the April 1 deadline, says an NHS business intelligence company.

By analysing public documents released by all 303 PCTs in England, Health Direction found that 43 per cent of PCTs had formed a pharmacy development group, established a medicines management committee and placed a community pharmacist on the professional executive committee.

In addition, 29 per cent of PCTs were involved in a national pharmacy pilot, such as repeat dispensing, and 14 per cent were involved in two or more national pharmacy pilots.

PCTs that showed some involvement ahead of the April 1 contract implementation date were more likely to progress with the new contract, said Health Direction NHS Information director Sue Knox. She added that these PCTs were more likely to commission services under the enhanced tier of the new contract.

However, the data showed that half of PCTs had made little progress in developing clinical governance processes for pharmacies, and just 17 per cent had completed baseline assessments and engaged pharmacists in their CG plans. **AF**

PRACTICE

Consultant pharmacists would help all

Community pharmacists could "piggyback" the consultant hospital pharmacist scheme by taking advantage of advanced courses, according to Hemant Patel, president of the Royal Pharmaceutical Society.

Speaking at an All-Party Pharmacy Group visit to St Thomas's Hospital on Monday, Mr Patel said that pharmacists would be able to develop clinical practice "while being able to retain face-to-face contact with patients in the community".

While David Webb, director of clinical pharmacy London, Eastern and South Eastern Pharmacy Services, said creating a consultant role for hospital pharmacists would benefit post-registration training for all and would improve services for patients beyond a hospital setting through their scope of wider health issues.

"A lack of career goal has been a turn-off for people entering the profession because they could not envisage how they would move up the career ladder," said Mr Webb.

Preliminary research revealed that only 12.8 per cent of current advanced pharmacists would qualify as a consultant. The title would be awarded through an application process after advanced training. Consultant pharmacists would be expected to divide their time between advanced practice and contributing to postgraduate education, research and national policy.

Assuaging fears that the new role could see a drop in the number of community pharmacists, Mr Webb said there would be more opportunities for specialists in community pharmacy. There are also hopes that specialist community pharmacists will develop contact with consultant pharmacists in the same way GPs with a special interest do with consultant doctors.

A report due next year will look at the possibility of pharmacists with a specialist interest working in hospitals two days a week to bridge the gap between pharmacy in primary and secondary care.

GOING FOR GOLD

A TRACK RECORD FOR BEATING ATHLETE'S FOOT

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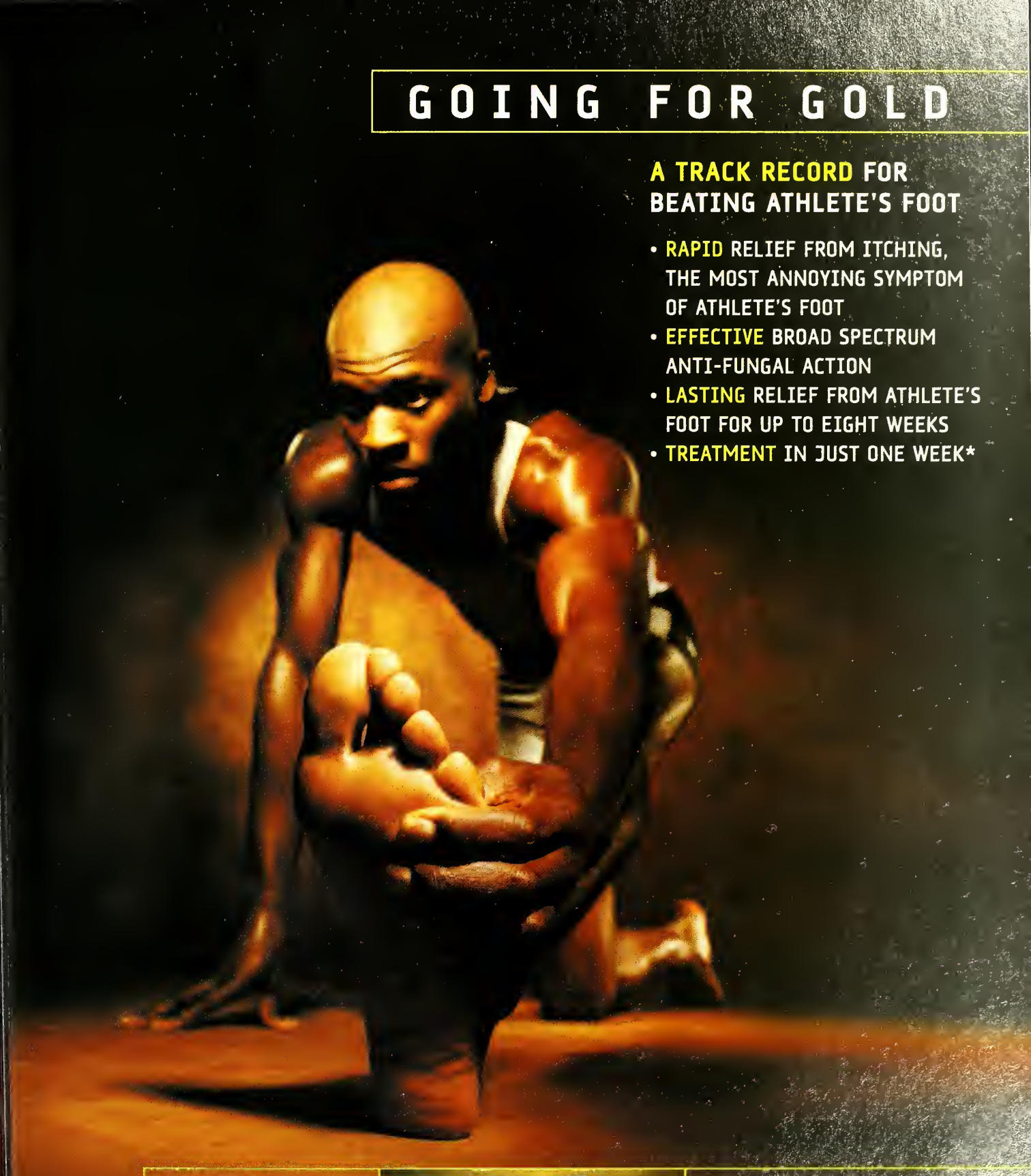
- EFFECTIVE BROAD SPECTRUM ANTI-FUNGAL ACTION
- LASTING RELIEF FROM ATHLETE'S FOOT FOR UP TO EIGHT WEEKS
- TREATMENT IN JUST ONE WEEK*



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*Based on IRI sales data 52 w/e 16 April 05

Product Name: Daktarin Gold. **Presentation:** Cream containing ketoconazole 2% w/w. **Indications:** For the treatment of the following [illegible] pedis, tinea cruris and candidal intertrigo. **Dosage and Administration:** For topical administration. For tinea pedis: Daktarin Gold [illegible] twice daily. The usual duration of treatment for mild infections is 1 week. For more severe or extensive infections (e.g. involving [illegible] be continued for 2-3 days after all signs of infection have disappeared to prevent relapse. For tinea cruris and candidal [illegible] twice daily until 2-3 days after all signs of infection have disappeared to prevent relapse. Treatment for up to 6 weeks may [illegible] experienced after 4 weeks treatment, a doctor should be consulted. **Contraindications:** Ketoconazole cream [illegible] to any of the ingredients or to ketoconazole itself. **Precautions:** Not for ophthalmic use. **Side Effects:** A few instances of [illegible] observed during treatment with ketoconazole cream. **Legal Category:** P. **PL Number:** PL 00242/0107. **PL Holder:** [illegible] Buckinghamshire, HP14 4HD. **Package Quantities, Price:** 15g tube, £4.99. **Date of Preparation:** February 2003

CONTRACT

PSNC advises on disability aids

by Gary Paragpuri

Pharmacists are not obliged under their terms of service to comply with prescribers' requests for instalment dispensing (unless treating drug misusers) or for medicines to be dispensed into compliance aids, PSNC is advising contractors.

Prescriptions should be dispensed on one occasion – other than for instalment prescriptions for the treatment of substance misusers – and it is for pharmacists to decide whether medicines need to be dispensed into a compliance aid, PSNC has clarified.

Further, where a new medicine is to be added to medicines already dispensed in a compliance aid as a DDA adjustment, then a new compliance aid should be prepared. But as there is no obligation for contractors to amend what has already been dispensed, prescribers would be obliged to make a DDA adjustment by issuing a prescription for all current medicines to allow for re-dispensing into a new aid. For this reason, prescribers could be advised to issue seven-day prescriptions if there are frequent changes to prescribed medicines, says PSNC. Where prescribers order in 28-day or longer periods but recommend that medicines are dispensed weekly or in compliance aids (for patients not entitled to this support under the DDA), PSNC says this should be "facilitated by a locally commissioned enhanced service".

For more information:

www.psnc.org.uk

CONTRACT

PCTs given help to monitor new contract

The NHS Primary Care Contracting Team is developing a toolkit to help assess compliance with the new pharmacy contract. It will give strategic health authorities and primary care organisations a core set of indicators and quality markers to evaluate implementation of the new contract.

PCTs will have to monitor whether essential services have been put in place by October 1, when the transitional arrangement ends, and ensure advanced services meet national criteria.

A working document is expected in July for pilot testing in August. The final version will be launched in early September via the Primary Care Contracting website and Strategic health authorities.

For more information:

www.psnc.org.uk
heather.gray@seherts-pct.nhs.uk or
david.common@salford-pct.nhs.uk

INDUSTRY

Napp fails in trademark battle

Cambridge based Napp Pharmaceutical Holdings Ltd has failed in a legal battle to register the phrase "Control Pain Live Life" as a trademark for painkillers and other associated pharmaceutical services and products.

Rejecting the company's application, trademark judge Ian Peggie said the term is one that "is devoid of any distinctive character.

"I am not persuaded that the mark 'Control Pain Live Life' in totality is distinctive in that it would serve in trade to distinguish the applicant's goods from those of other traders. In my view the mark applied for will not be identified as a trademark without first educating the public that it is one."

Napp Pharmaceutical wanted to use the phrase to promote a new pharmaceutical product range.

The judge described the phrase as being "no more than an advertising strapline".

Napp had argued that the target audience would be medical professionals and pharmacists only so there would be "no connotational link between the mark and the goods and services covered". **UKL**

PRACTICE

Gluten-free patient guide

Gluten-free foods: a patient's guide to prescriptions is a new A5 guide designed to raise patients' awareness of the condition, minimum gluten-free food intake recommendations and the process for getting foods on prescription.

The guide, which is supported by an educational grant from SHS and Nutricia, complements the existing healthcare professional's resource: *Gluten-free foods: a prescribing guide.*

Contract clauses targeted by defence body

by Anna Goldie

The Pharmacists' Defence Association has identified more than 20 problematic clauses in employment contracts that lead to some of the 400 disputes the association handles each year.

The PDA has produced a booklet to help any employee and locum pharmacist signing contracts governing their employed or self-employed relationship in response to the findings.

The booklet, *Dealing with, and overcoming problems in Contracts*, aims to highlight specific problem clauses, making both pharmacist and employer better informed.

PDA director Mark Koziol said the guide was a form of "risk management".

"It is hoped that pharmacists will be more aware of the issues and that they will avoid signing contracts that contain these clauses in the future." Mr Koziol added that he hoped employers would read the guide to make sure their contracts did not contain any "potentially destructive clauses".

The guide offers alternative solutions to traditional contract clauses such as working hours, termination of contract and work location.

Last year the PDA secured more then £150,000 in compensation for its members after employment disputes.

Pharmacists can download a copy of the guide from the PDA website or by contacting the association on 0121 694 7000.

New DAWN for pharmacies

Photographic supplier Colorama has launched a new dual function kiosk offering combined shopping and digital print services for pharmacies.

Colorama teamed up with Mitsubishi Electric to produce the Delivery Assured Weekday Nextday unit, which blends touch-screen selection of consumer goods with an instant photo print service.

The unit, which occupies 1m sq of floor space, could provide a valuable trade boost for independent pharmacies, according to Colorama.

Managing director Arun Patel commented: "Pharmacists are often tied to monitoring dispensing behind the counter. DAWN gives them a 'two in one' self-service option, which lets them build extra revenue into their business without big overheads, high investment or huge disruption."

DAWN will offer hundreds of continually updated product lines, which range from walking sticks to DVDs, according to Colorama. Customers will receive a receipt following purchase and can collect the product the following day from their pharmacist.

DAWN units are available to rent from £100 to £160 a month. Colorama will provide operators with 24-hour technical support, and promotional marketing material for the service. **MG**

For more information:
Tel: 087 0040 0030

NPA VIEW

Training: your lynch pin

The time is right to assess the training needs of everyone who works in the pharmacy, says Lesley Johnson, NPA head of education and training

Everyone is talking about the implementation of the new pharmacy contract and our members are working hard to interpret the specifications of the services, adapting their practice to meet requirements and to be in a position to offer advanced and enhanced services.

For some it is a daunting challenge, yet with well trained and motivated staff, the delivery of services under the contract will be much easier. As training professionals, we will always talk about the benefits that training provides, but now, more than ever, training will be the lynch pin on which the future survival of many pharmacy businesses depends.

Now is the time to assess the training needs of all pharmacy staff, including the pharmacist, locum or permanent and all support staff.

For example, is there a suitably trained member of the dispensary team delegated to do the 'final accuracy check'?

If so, the pharmacist can be released from the mechanics of dispensing and gain the opportunity to take a step back and survey the business from a more strategic aspect.

The right training of each and every member of the pharmacy team can streamline every activity, ensure that the essential and advanced services can be provided, and, when you bid to offer enhanced services, you will have the skills in place.

A locum can be a vital member of any pharmacy team, whether regular or occasional.

Staff training can continue when a locum pharmacist is in charge, providing there is clear communication between all parties.

Locums also have training needs and now have the opportunity to become NPA Link members, providing them access to some of the resources provided by the NPA.

Pharmacy support staff will need to be kept up to date with the developments of the new contract and how it will affect everyday practice of the pharmacy. The NPA has introduced *The NPA Pharmacy Support Staff Guide to Essential Services* to help them understand how the new contract will affect everyday practice.

Underpinning this, we have developed a learning pathway for support staff so that one course leads to the next.

We have been striving to ensure that we can provide all the training resources needed for the entire pharmacy team; advice, high quality training materials, course administration and first class support to students and pharmacists.

Our unique approach to the development of our courses and course materials provides the support you need to use the NPA as the lynch pin of your training needs.

For a course prospectus and information about NPA training resources please [illegible] 01727 858687 ext 3475.

For information abo[illegible] Link membership visit *www.npa.co.uk* [illegible] Departments, th[illegible] or call: 01727 858[illegible]

Comment from the Editor

The man in charge of implementing the NHS's IT programme has stimulated debate on how online pharmacy services could impact on 'bricks and mortar' pharmacies.

Will internet pharmacies take over so much dispensing once electronic transmission of prescriptions is rolled out that high street pharmacies collapse? Sub-post offices are used as an example: the payment of pensions and benefits directly into bank accounts has affected the viability of many sub-post offices.

But many pharmacy IT experts think this is an extremist view. Not only will community pharmacy diversify under the new pharmacy contracts, but the sloth-like progress of the NHS IT programme suggests community pharmacists will have plenty of time to react.

And according to the NPA's Neal Patel *(p24)*, there are other avenues opening up to pharmacies, particularly around the commissioning of health services. This is what should be influencing community pharmacy contractors seeking to secure their livelihoods.

The new general medical services contract is not a contract for GPs alone, but for anyone wanting to provide all sorts of medical services. But while pharmacists can tender for some of these general medical services, they should be aware that certain pharmacy services will also be open to competition.

Pharmacists, therefore, need to make sure they know what services are needed within their locality and what is being commissioned. If they don't, then someone else may take that opportunity. So it's up to individual pharmacists to look outside of the box and see what is going on around them. Make sure you know what your PCO's plans are. Otherwise you may find the prophets of doom are right, albeit for the wrong reasons.

"Certain pharmacy services will be open to competition"

Your views

E-mail your views to chemdrug@cmpinformation.com

Our question to pharmacists this week was:

Do you want original pack dispensing to be made mandatory?

"It's terrible to have to cut strips all the time, especially if people need one or two pills"

Heather Simonds, Surrey

"Original pack dispensing might be a bit bulky but it saves us from snipping"

Mr Madlon, Doncaster

"I can see it from both sides"

Clare Donnelly, Leeds

Our online poll at *www.dotpharmacy.com* said...

Yes – it saves time, waste and dispensing errors

Yes – if pharmacists consulted on pack designs

No – original packs are too bulky and expensive

Independents need to think positively, says Mark Stephenson

It's not all bad news

In response to Mark Griffiths' comments concerning the future of independent pharmacy (*C&D, July 9, p16*), I would like to offer my thoughts.

As Mr Griffiths points out, this month's remuneration for many pharmacists will be a disappointing affair. A tough start to the year means that the belts are tightening for pharmacists and wholesalers alike.

However, with the new contract comes new opportunity and it is the responsibility of the wholesaler to assist its customers in realising the full potential of this. While we all recognise that money has been taken out of the dispensary, an increased focus on patient care services opens up new, previously untapped income streams and greater opportunity for independent pharmacy to utilise its unique position in the marketplace to stay ahead of the competition.

Screening and diagnostic services are just one example of revenue sources that can be generated under the new contract. Not only will such services enable pharmacists to utilise their clinical skills and build customer loyalty, the accompanying equipment that can be sold through pharmacy is an important additional income stream.

Training, both for pharmacists and support staff, is integral to the provision of such services. UniChem hosts new contract workshops around the country to support pharmacists in mastering the new skills that will be required

Mark Stephenson: training is integral to provision of services

Continued on opposite page

Continued from previous page

of them in this new era and this type of support is proving extremely useful to those seeking to progress under the new contract.

Furthermore, as many pharmacists are already aware, a premises upgrade, which maximises retail space and includes a consultation area, is a wise investment for any contractor looking to move their business forward.

In this competitive marketplace

A focus on patient care services opens up previously untapped income streams

image is more important than ever, and those who invest in their premises will reap the rewards of higher footfall and increased sales.

Add to this, the local community knowledge, entrepreneurial skills and freedom that independent pharmacy possesses, place it ahead of its multiple counterparts and I firmly believe that the "decline" Mr Griffiths refers to is wholly avoidable.

Wholesalers too have been impacted by the changes in the marketplace in the early part of 2005. By working in partnership with independent pharmacy we seek to establish a brighter, more profitable future for both parties under the new contract.

With a wealth of young pharmacy students struggling to find pre-reg places there is certainly no lack of willing recruits to the profession.

At UniChem, our 'Own Your Own Pharmacy' roadshows encourage these young hopefuls to take the independent route.

What are we telling them?... that this is simply the most exciting era that pharmacy has ever seen with the Government recognising the important role that pharmacists have to play in protecting the nation's health. What's more, there are a wealth of opportunities in independent pharmacy for those who are brave enough to seize them.

Mark Stephenson is marketing director at UniChem

TOPICAL REFLECTIONS

The crazy world of European law

Cartoon by Don Seed

I hope someone in the Government was listening when the NPA urged it to "face up to its obligations, put its hand in its pocket and make the regulatory changes necessary to allow the routine use of patient packs" (*C&D, July 16, p12*). I am already breaking the law several times a day when I dispense prescriptions without a PIL and it sounds like I will become even more of a criminal when Braille labelling requirements become law in October.

I am generally a law-abiding citizen but the idea of photocopying PILs to include with every prescription is so ridiculous that my conscience remains perfectly clear. I do not understand how the Government can introduce a law and not make it practical to adhere to that law, unless of course it has no intention of enforcing it.

Braille labelling on all patient packs is a great idea, particularly for countries that rely on original pack dispensing. Labelling dispensed packs in Braille however, is impractical and in reality I simply won't bother (oops, another law broken). Parallel imports create another dilemma, where the Braille writing is often on the other side of the box to the English over-label – where do I stick my label?

The stupidity of the whole thing is made worse by the fact that common sense is never allowed to prevail. Why couldn't I, for example, save all the Braille packs for those patients I know have sight problems? Everyone else can have whatever perfectly good packing is available, labelled clearly in English and nine times out of 10 receive a PIL. And what good is a PIL to someone who can only read Braille anyway? There are other reasons why universal patient packs are a good idea. Apart from the considerable time saving, I will never again be embarrassed about dispensing 14 tiny bits of foil, each containing two Coversyl tablets against a prescription for 28. But I only ever do that to patients with good eyesight of course.

An important role in the battle against terror

In the aftermath of the recent terrorist attacks on London, the nation pulled together in a show of mourning and defiance. And pharmacy played its part in the network of co-operation that enabled the capital to cope with the disaster (*C&D, July 16, p4 and 5*).

The profession is often at the forefront of battles against pervasive evils, such as tackling drug misuse, NHS fraud and, more recently, rogue elements of the medical profession. As it emerges that some of the explosive used in the London bombs may have been home-made we have been handed an important role in the fight against terrorism.

Chemicals available from pharmacies that can be used to make explosives include chlorates, nitrates, magnesium, potassium permanganate, sulphur, powdered aluminium and phosphorus. Requests for any of these materials will be referred directly to me and I will not sell them without exceptional reason. I feel proud to be able to play my own small part in a battle that must be won.

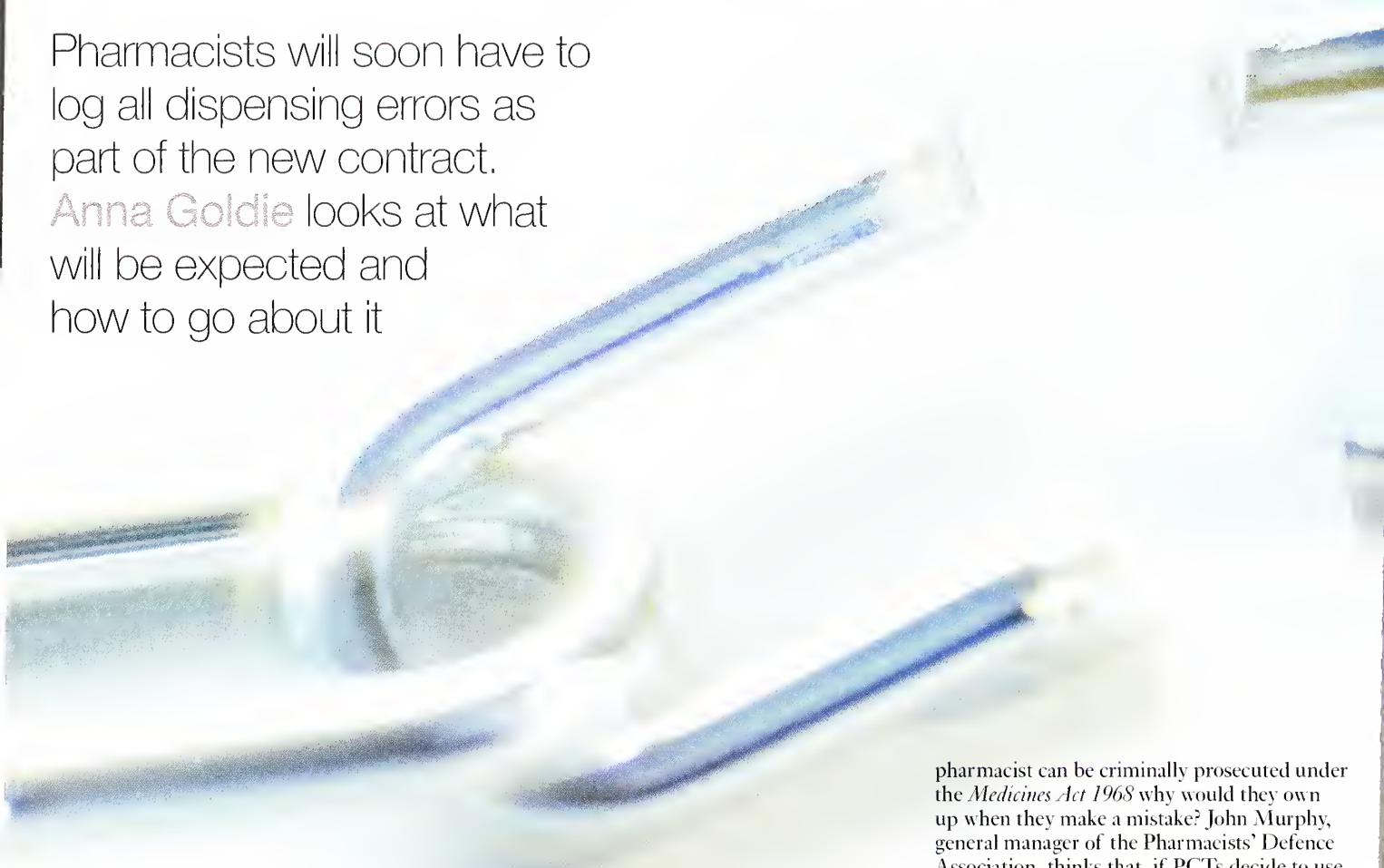
There's nowt as queer as folk

The PAGB survey on self-care (*C&D, July 16, p32 and 33*) is a fascinating insight into how the public regard their own health. It also reveals the difference between what people say and what they actually do, which I guess is one of the difficulties of carrying out a survey of any sort.

It simply doesn't make sense that, while 77 per cent of respondents believe that pharmacis[illegible] a good source of advice, only 8 per cent re[illegible] ask them for any. And who are they tryin[illegible] impress with their claims of a healthy li[illegible] their healthiest activity is to "limit" sm[illegible] Perhaps if they asked their pharmacist, th[illegible] stop altogether.

When things go **wrong**

Pharmacists will soon have to log all dispensing errors as part of the new contract. Anna Goldie looks at what will be expected and how to go about it



To err is human, but mistakes in pharmacy can have serious consequences, and whether we admit them or not, mistakes happen. When the new pharmacy contract in England and Wales moves out of its six-month transitional phase in October, pharmacists will be expected to keep a log of all dispensing errors and primary care organisations will have the right to ask for evidence of error reporting as part of their performance management remit.

The reform of the NHS over the past decade has seen the NHS become more transparent, accountable and honest. While hospital pharmacies and many multiples have had their own error reporting systems for a number of years, community pharmacists have not been obliged to own up to mistakes in the same way.

Research commissioned by the Community Pharmacy Research Consortium and carried out by Manchester University set out to find a way of creating a working culture where pharmacists, counter staff and technicians feel able to admit mistakes without fear of reprisal. More importantly, the data from incident reports will be used to improve patient safety and even make working life for pharmacists easier. The National Patient Safety Agency hopes pharmacists will join other healthcare professionals in using a specially designed form on the internet to report incidents.

But trust will be a major factor in the success of the new system. After all, if a pharmacist can be criminally prosecuted under the *Medicines Act 1968* why would they own up when they make a mistake? John Murphy, general manager of the Pharmacists' Defence Association, thinks that, if PCTs decide to use the data against the pharmacy, legal privilege should apply. "If a PCT expects pharmacists to report errors they are in danger of incriminating themselves which goes against the Human Rights Convention."

To get around this, the error reporting form has been made anonymous to encourage pharmacists to report and to get the most from pharmacists' natural vigilance, says Wendy Harris, senior pharmacist, safe medication practice in primary and secondary care at the National Patient Safety Agency. "The pharmacist is the last person in the chain as a safety barrier," she says. Prosecutions are still very rare and anonymity is enshrined in primary legislation. "Error reporting is about trusting people to share information that they have had for a long time, like raising concerns about similar packaging, the quality of information on parallel imports or drugs initiated in hospitals that they don't hold licences for."

The changing nature of the NHS and the increasing prescribing powers being given to pharmacists is a good reason to start a new culture change within pharmacy, according to Ms Harris. But research has shown that old habits die hard and encouraging pharmacists to make a note of mistakes means fostering a 'fair blame' environment where all staff benefit from the lessons learnt by errors, instead of feeling in danger of losing their job or the respect of colleagues.

The legal view

Although prosecution is rare, the fact that pharmacists are under strict liability for mistakes means many have been wary of drawing attention to errors. There have been calls for the law to change in line with other healthcare professionals but until it does pharmacists will have to run the risk of prosecution every time they admit a dispensing error.

David Reissner, expert in pharmacy law at Charles Russell lawyers, says error reporting should be decriminalised if it will encourage people to report. "It's time Parliament looked at the *Medicines Act* again, it's a hang-over from the days when pharmacy wasn't as highly regarded as other medical professions." But Mr Reissner also thinks that pharmacists need to take the lead and that the RSPGB could even publish guidance as to when a pharmacist could expect legal intervention." The RPSGB shouldn't expect to have it both ways and expect pharmacists to report errors when they run the risk of prosecution or disciplinary action."

Agreeing with Mr Reissner's call for guidance, John Murphy of the Pharmacists' Defence Association, says: "Very clear guidelines are needed about how PCTs will use the data to make sure they point to systems in error and not individuals."

Manchester University researchers found support staff have often been reluctant to challenge a pharmacist's mistakes and many avoid reporting errors out of feelings of loyalty and sympathy towards colleagues or fear of being disciplined. In fact they also found that a "prevailing blame culture meant errors were covered up". Sticking doggedly to rules also meant the same mistakes were often repeated. Root-cause analysis has shown that making sure practices are flexible enough to accommodate systems that aren't working and encouraging staff to actively question a new situation or protocol means potential pitfalls can be avoided.

Over 600 million prescriptions are dispensed every year in the UK and Manchester University's researchers found that on average out of every 10,000 drugs dispensed there were 22 near misses and four dispensing errors. Out of those the most common at 60 per cent and 33 per cent respectively were selection and labelling errors. Twenty one per cent of dispensing errors were caused by misreading prescriptions, while 17 per cent were caused by confusion between similar drug names. Researchers found staffing shortages and distractions also caused mistakes, with counter assistants often taking the role of dispenser at busy times, increasing the risk of error.

Pharmacies already reporting

Stephen Thomas, deputy superintendent pharmacist, Rowlands Pharmacy:
"Rowlands had a reporting scheme in place for about three years before I joined the company and for the past 18 months we have been refining it.

"We ask all employees to report any errors that reach the patient (either detected in the pharmacy by the patient or at their home). We have a 'fair blame' culture because any errors that are reported foster learning in the company.

"Often when new people join the company they take a while to feel comfortable reporting an error, especially as our system isn't anonymous, but because nothing untoward happens they begin to feel comfortable towards the system.

"All errors are entered into a database as they arrive and each month I carry out an audit to look at root cause analysis and for reccurring patterns. Each month our newsletter has a section concerning the previous month's common errors and 'things to look out for'. Last year we had an example of confusion between bendrofluazide and bumetamide because the packaging was very similar. We flagged it up in the company newsletter and told staff to put a different product or piece of card between them or a warning sign to avoid the mistake again.

"Because locum pharmacists are often left out of the loop, once or twice a year I look out for locums whose names have appeared more frequently in error reports and write to them about their clinical practice. As part of the new contract we will have to monitor near-misses as well – at the moment we are developing a system to enable this."

Alastair Buxton, head of NHS services at the Pharmaceutical Services Negotiating Committee, says measures such as practice payments and minimum staffing levels have been put in place to help avoid workload related mistakes. "Pharmacists will need to learn how to work differently under the new contract" he says. "But a good pharmacy will be reporting errors anyway as a sign of good clinical governance and reviewing practices; I would expect a lot of pharmacists to choose error reporting as part of their continuing professional development."

The NPSA already issues warnings when confusion arises over medicines, for example similar drug names Repevax and Revaxis caused problems after 93 children were given the wrong vaccine in March. The agency hopes to use error reporting data to avoid such mistakes happening again.

David Pruce, director of practice quality and improvement at the Royal Pharmaceutical Society, thinks learning from mistakes is vital. "The sinking feeling you have after making a mistake changes the way you work for the rest of your professional life for the better," he says. "The NPSA have agreed to share the data with us so we can learn lessons and implement best practice. If people feed into the database and nothing comes of it they won't bother to do it again."

Together the NPSA and the RPSGB believe the only way mistakes can be avoided, and working life made easier for pharmacists, is by encouraging them to speak out when they find medicine names or packaging too similar and to learn about the root cause of errors. Simple things like improving lighting in work spaces, or making sure that drugs with similar names or packaging are kept separately are small measures that can have a big effect.

The sinking feeling you have after making a mistake changes the way you work for the rest of your life

What to expect from error reporting

The NPSA estimates that each error report form will take about six to eight minutes to complete. Pharmacists can print out a copy of the completed form to keep for their own records and to share with their PCT. The following are examples of some of the questions you should expect to be asked:

1. Date and time of error.
2. Type of mistake, for example was it clinical assessment, documentation, medication or to do with pharmacy infrastructure?
3. Was the patient harmed?
4. Where did the incident take place?
5. Contributing factors, such as a lack of training or equipment facilities, communication or environment difficulties, such as poor lighting.
6. At what stage in the medication process did the error occur? (prescribing, dispensing, supply etc).
7. Was the error caused for example by the use of abbreviation in drug name, or wrong strength, dosage or directions?
8. Staff type and status.
9. Factors associated with the incident such as parallel imports.
10. You will have the option to send an electronic copy of the error report to share with your local PCT.

Simple steps to avoid errors

1. Make sure there is adequate lighting to read prescriptions clearly.
2. Keep similarly packaged or named drugs separate, or place a warning nearby.
3. Encourage staff to question practices and offer solutions.
4. According to the Department of Health, the 10 drugs most commonly associated with dispensing errors include:

- prednisolone
- MST
- warfarin
- isosorbide mononitrate
- aspirin
- lisinopril
- carbamazepine
- diclofenac
- co-codamol
- flucloxacillan

5. Include both the generic and brand name on dispensing labels.
6. Blister packs should be supplemented with manufacturers original packaging if a
7. Labels should be read three times in the dispensing process to check the name, strength and formulation.

Sources include the Department of Health, Manchester University and the National Patient Safety Agency

Chloramphenicol eye drops are now available OTC. [redacted] reviews what pharmacists and their staff need to know before making a sale

An eye for an **eye**

Pharmacists' much longed-for wish to sell chloramphenicol for minor eye infections was granted by the UK drug regulator last month (*C&D, June 11, p5*). This article summarises the training packages that have already been launched by the product manufacturers and acts as a quick reference guide for pharmacists and their staff.

What is it, and who is it for?

Chloramphenicol 0.5 per cent w/v eye drops are licensed for pharmacy sale for the treatment of acute bacterial conjunctivitis in adults, including the elderly, and children aged two years and over. The lower age limit has been set at two years following rare reports of leukaemias and grey baby syndrome.

The drops are contraindicated in patients who are hypersensitive to chloramphenicol or any other product ingredient, and in those who have a history, or family history, of blood dyserasias including aplastic anaemia. Concomitant use with other drugs liable to depress bone marrow function should be avoided, as should concurrent use with chymotrysin (an enzyme involved in the breakdown of proteins in the small intestine).

Chloramphenicol crosses the placenta and enters breast milk, so the product should not be used by pregnant or breast-feeding women.

How do I diagnose and differentiate between various types of conjunctivitis?

Conjunctivitis is an acute inflammation of the transparent membrane that covers the front of the eye (except the cornea) of infective, allergic or irritant cause.

Infective conjunctivitis may be caused by bacterial or viral infection. In adults, the most common bacterial pathogens are *Staphylococcus* species, *Streptococcus pneumoniae* and *Haemophilus influenzae*, whereas in children, *H influenzae, S pneumoniae* and *Moraxella catarrhalis* tend to be the causative organisms. Viral conjunctivitis, usually caused by an adenovirus, tends to be associated with upper respiratory tract infections, such as a cold or sore throat. Bacterial causes are more prevalent in children, but viral conjunctivitis is more common in adults.

Current medical practice does not attempt to differentiate between bacterial and viral conjunctivitis, and in the pharmacy setting it is appropriate to treat any superficial infective conjunctivitis with chloramphenicol, as long as the patient does not meet any referral criteria (*see later*).

The symptoms of infective conjunctivitis are: inflamed, red or pink eyes; discharge, which is mucopurulent if bacterial and may crust on the eyelids and make eyes difficult to open on waking, or watery if viral; usually, but not always, unilateral initially; discomfort described as gritty or burning, not sharp or significant; normal vision, though discharge may cause temporary blurring, particularly on waking.

Allergic conjunctivitis may be seasonal (associated with allergic rhinitis or hay fever) or perennial. The symptoms include: itchy eyes; watery discharge; bilateral; eyes may feel as though they are burning; tends to be recurrent and associated with contact with the allergen.

Irritant conjunctivitis may have a mechanical cause, such as eyelashes rubbing against the surface of the eye or a foreign body lodged beneath the upper eyelid, or be caused by chemicals, for example chlorine in a swimming pool. Patients with suspected penetrating eye injuries should be referred urgently.

How should the drops be used?

Patients should be counselled to use one drop in the affected eye(s) every two hours for the first 48 hours and every four hours thereafter. This regimen need only be followed during waking hours, and the total duration of treatment should not exceed five days, except on the advice of a doctor. The drops should be stored at between 2 and 8°C in a dry place. In addition, the product packaging or patient information leaflet will state the following:

- Seek immediate medical advice any time if symptoms worsen.
- Consult your doctor if your eye infection does not start to improve within 48 hours.
- Discard after a five day course of treatment.
- Do not use if you are allergic to chloramphenicol or any of the ingredients.

Despite the labelling, it may be worth reminding patients of the circumstances under which they should seek further medical advice. As a final counselling point, patients should be advised that the drops may cause transient blurring of vision, and they should ensure their eyesight is clear before operating machinery or driving.

Who should be referred?

Patients presenting with any of the following should be referred to their doctor: severe pain within the eye; disturbed vision; photophobia; unusual looking pupil; eye looks cloudy; associated pain or swelling around the eye or face; recent conjunctivitis; glaucoma; dry eye syndrome; eye injury; suspected foreign body in the eye; concurrent eye medication; eye surgery or laser treatment in the last six months.

Contact lens users should generally be referred, unless they are requesting the product following advice from a contact lens practitioner or doctor. If this is the case, contact lenses should not be worn during treatment. Hard or disposable lens wearers can start using their lenses after successfully completing a course of treatment, but soft contact lens wearers should wait 24 hours after completing a treatment course before reinserting lenses.

What are the side effects?

The most common adverse effects are local sensitivity reactions. Transient irritation, burning, stinging, itching and dermatitis have been reported, and sometimes the drops can be tasted or affect taste as they drain from the eye into the back of the mouth.

Although rare, systemic reactions including adverse haematological events (bone marrow depression, aplastic anaemia and death) have been reported following ocular use of chloramphenicol.

The prolonged use of eye drops containing a phenylmercuric preservative has been associated with skin irritation, corneal changes and pigmentation of the anterior capsule of the lens (mercurialentis).

This article can help in the following CPD competencies: G1a, G1c, C1f. A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

This article can help in the following CPD competencies: **G1a, G1c, C1d, C1f, C4f.** A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Iron: good or bad?

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1343), in association with multiple choice questions being published in *C&D* August 6, provides one hour's continuing education

Objectives

- To know the main forms and sources of dietary iron
- To be aware of the functions of iron
- To understand how the body regulates iron
- To recognise who might be deficient
- To know who should avoid supplements

Nutritionist *Ann Walker* looks at the benefits and risks of iron

Iron defieiency anaemia affeets hundreds of millions of people worldwide and the part played by iron in the structure of haemoglobin and its oxygen-earrying capacity in red blood eells (RBCs) is well known.

However, iron's other roles are less well known. It is a eomponent of many respiratory enzymes found in all cells of the body and so iron deficiency, even in the absence of anaemia, ean reduce work capacity, impair mental ability, cause behavioural ehanges and lower resistance to infeetion. But people carrying the genes responsible for haemochromatosis, in which iron absorption is pathologieally increased, need to keep their dietary iron intake low. They should not use supplementary iron, as they are susceptible to iron overload, eausing free radieal damage and inereased risk of diabetes.

Sources

There are two forms of dietary iron: haem and non-haem. Haem iron ean bind to the proteins haemoglobin or myoglobin and is uniquely found in red meats and fish. Non-haem iron is found as inorganie compounds in meat, cereals and cereal products, leafy vegetables, nuts, seeds and dried fruits.

Non-haem iron is poorly absorbed and its absorption is further hindered by the presence of dietary fibre, phytates, oxalates, tannins and vegetable proteins in plant foods, and by calcium and phosphate in supplements. Enhancing factors for absorption are vitamin C and protein from meat and fish. Acidic foods and low stomach pH also aid non-haem iron absorption by promoting the conversion of ferric to ferrous compounds. Between 5 and 35 per eent of haem iron is absorbed from a single meal, whereas only between 2 and 20 per cent of non-haem iron is absorbed.[1]

The average daily intake per adult in the UK, according to the National Diet and Nutrition Surveys (NDNS) is 10.9mg of non-haem iron and 0.7mg of haem iron.[2] Nevertheless, haem iron accounts for about a third of absorbed iron among non-vegetarians. *Figure 1* shows the food groups that contribute to the intake of non-haem iron in the UK. In general, the absorption of iron from a mixed diet is about 15 per cent, but the vegetarian diet contains iron in a less well-absorbed form so vegetarians may need higher intakes.

Milk formulas for babies contain higher iron eoncentrations than breast milk to compensate for its lower absorption: while breast-fed infants can absorb 50 per eent of the iron they take in, bottle-fed babies only absorb 10 per cent.

Function

Iron is a transition element and is eapable of existing in two redox forms (ferrous and ferric), which means that it readily acts as an electron donor or acceptor. This property gives iron an important role in biological processes such as the transport of oxygen and eleetrons. But it can also make iron toxic, because excess can promote oxidative damage and harmful free radical formation. Iron homoeostasis is therefore tightly regulated and the body avidly prevents the presence of free iron by means of specific iron-binding proteins.

The healthy human body contains 3 to 4g of iron, with about 75 per cent in functional use and the rest under storage. Most of the "functional" iron is present as haem proteins: haemoglobin in blood and myoglobin in muscles. The remainder of the "functional" iron is a tiny fraction of total body iron and found in the cytochromes (a group of haem-containing electron transport enzymes necessary for generation of ATP and detoxification processes).

Catalase and peroxidase (involved in the disposal of the hydrogen peroxide generated from metabolism) are also iron-containing enzymes and there are others essential for mitochondrial respiration.

Iron homoeostasis is controlled by the regulation of absorption. The percentage absorption depends on body iron status, varying as much as 20-fold for non-haem iron but only two-fold for haem iron. The absorption of both haem and non-haem iron mostly takes place in the duodenum by separate mechanisms.

Figure 1: Percentage contribution of food types to average daily intake of non-haem iron[2]

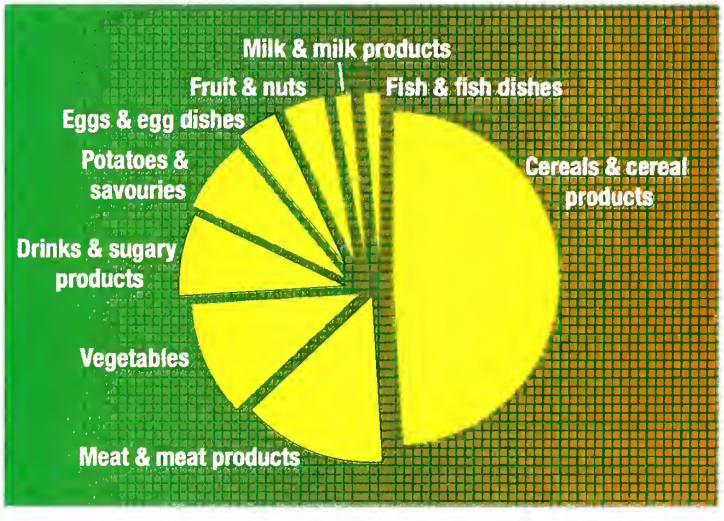


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Figure 2: UK Reference Nutrient Intake (mg/day) for iron[4]

Age (years)	0-1	1-3	4-6	7-10	11-18	19-50+	50+	Lactation
Male	1.7-7.8	6.9	6.1	8.7	11.3	8.7	8.7	
Female	1.7-7.8	6.9	6.1	8.7	14.8	14.8	8.7	14.8

Absorption of non-haem iron is down-regulated by the release of the newly identified iron regulator hepcidin, a peptide that is synthesised by the liver when iron stores and red blood cell numbers are adequate.[3] Iron losses from the body are low and are not regulated: men lose about 1mg per day, while in women losses are higher – an average of 1.5mg/day – the additional loss being due to menstruation.

After absorption, iron is bound to the iron-transport protein, transferrin, for distribution around the body. Iron not bound in this way is lost by exfoliation of intestinal epithelium into the faeces. RBCs account for a high percentage of total body iron. At the end of their lifespan (120 days), they are phagocytosed by macrophages, mostly in the spleen, but also in bone marrow and the liver. Haem is separated from globin, and iron is released and returned to the plasma as transferrin. Iron is stored as ferritin in the spleen, bone marrow and liver.

Requirements

Figure 2 shows the Reference Nutrient Intake (RNI) for iron according to age and gender.[4] Times of rapid growth lead to increased blood volume, which in turn increases iron requirements (hence the higher requirement of teenage boys). Menstrual blood loss in women of reproductive age almost doubles their requirements compared with men. However, women have a higher rate of absorption during their reproductive years to compensate for this.

Maximum safe intake and toxicity

Iron can be exceedingly harmful to infants and young children under three years and single accidental doses of 900mg have been fatal, caused by free radical damage to the gastrointestinal tract, liver, heart and blood clotting mechanisms. Acute iron poisoning has most often occurred in young children eating iron tablets as "sweets". Because the body cannot excrete excess iron, chronic iron toxicity may occur by the gradual accumulation of iron entering the body in amounts greater than its requirements.

For healthy people, the non-haem iron present in supplements carries little risk of over-absorption because of down-regulation of absorption once iron stores are replete. Although supplemental intakes as high as 60 mg/day have produced no adverse effects in pregnant women, it is desirable to avoid high iron intakes to prevent excess free radical activity in the colon. The UK Expert Committee of Vitamins and Minerals (2003) has set a Safe Upper Level (SUL) of 17mg/day of iron from supplemental sources for long-term use for adults.[5]

An association between high serum ferritin and coronary heart disease found in some early studies has not been confirmed in other studies. However, increased heart disease risk has been noted among people with hereditary haemochromatosis, who can have exceptionally high ferritin stores.[6]

The disease is now understood to be related to lack of hepcidin secretion by the liver, which is necessary to "switch off" non-haem iron absorption.[3] Iron absorption is, therefore, increased and iron overload results with the pathological deposition of iron in liver, heart and pancreas.

The clinical consequences include changed skin pigmentation, cirrhosis of the liver, increased risk of liver cancer, cardiac dysfunction, diabetes and hypogonadism. Treatment includes physical removal of iron from the body by phlebotomy. Other conditions of iron overload from dysregulation of iron homoeostasis are less common, and include thalassaemia.

Iron intake and deficiency

There is no doubt that the burden of iron deficiency falls more heavily on women than men. For women of child bearing age, over 80 per cent failed to reach the RNI in the NDNS surveys (*see Figure 3*).[2] After the menopause, the RNI is reduced. Even so, over 60 per cent of older women failed to reach their target in the surveys.

Is there evidence of iron deficiency among women in the UK? The NDNS surveys included blood analysis, which showed, surprisingly, that only 8 per cent of women were below the recommended 12g/dl or more for haemoglobin. However, serum ferritin concentration is thought to be the best single measure to diagnose uncomplicated iron-deficiency anaemia (infection can complicate the picture, as serum ferritin rises as part of the acute phase response). While the criteria for deficiency used by the NDNS was less than 15mcg/l serum ferritin for women and less than 20mcg/l for men, other authorities advocate less than 20mcg/l for both genders.[7] This would mean that about 20 per cent of women in the UK survey were iron deficient (compared with 4 per cent of men). Other groups in the UK population vulnerable to iron deficiency are infants and toddlers, adolescents and pregnant women (due to high physiological requirements or high blood losses) and those having poor absorption (the elderly).

Low body iron status leads to a reduction in iron content in all functional compartments. The well-known consequences of iron deficiency are decreased RBC haemoglobin concentration, decreased size and volume of new RBCs, reduced myoglobin, and reduced amounts of cytochrome enzymes within cells. Severe deficiency manifests as inflammation around the mouth and tongue, restriction of the oesophageal lumen, gastritis, spoon-shaped fingernails and taste changes leading to pica (consumption of non-food items, such as compulsive ice eating).

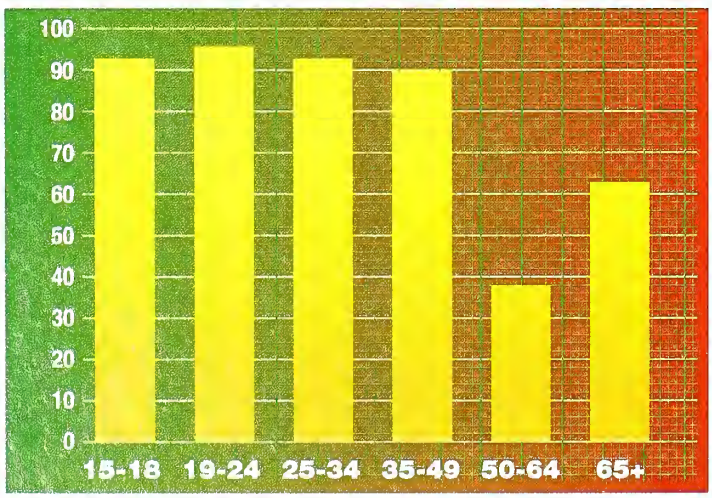
Less severe dysfunction caused by marginal deficit can result in increased susceptibility to infection, reduced exercise performance, impaired mental development and cognitive function.[8] Although the non-haem iron of cellular enzyme systems constitutes only 1 per cent of total body iron, deficit of these enzymes has been shown to have profound detrimental effects on athletic performance.[1]

Supplementation

Iron supplementation should aim to replete any deficit, as iron overload increases risk of diabetes.[9] Fortunately, for healthy people, because non-haem iron absorption is low, the iron content of multinutrient supplements pose no risk. Indeed, the absorption of iron from multinutrient preparations, especially when calcium salts are present, is less than that from single iron supplements.[1]

Reduced absorption also occurs if iron is taken with a meal or with coffee and tea: one iron tablet taken daily without food has been shown to be as effective as three taken with meals. For people with diagnosed iron deficiency, therefore, the use of single iron

Figure 3: Percentage of women in NDNS surveys with daily iron intake less than RNI



Haem iron is uniquely found in red meat and fish

supplements, taken two hours away from meals or calcium supplements, would be advisable.

Those who might benefit from iron supplementation include women with high menstrual losses and pre-menopausal vegetarians. Because there is an inverse relationship between iron absorption and body iron stores, iron supplementation should be long term and continuous to overcome deficiency.

In diagnosed deficiency states, the recommended oral dose of elemental iron is as high as 100-200mg daily. This is usually given as ferrous sulphate 200mg (where 200mg is equivalent to 65mg elemental iron).

An obstacle to iron supplementation of doses greater than 14mg/day is the transitory nausea that can occur 30-60 minutes after ingestion, but this usually subsides after two to three days of continued treatment. Drinking plenty of fluid at the same time usually helps. High iron doses commonly cause constipation, which can be relieved by lowering the dose.

Although iron overload is unlikely to occur in healthy people even on high iron supplementation, the same is not true for people who are genetically predisposed to haemochromatosis.[6] Such people should not use supplementary iron and are advised to minimise their intake of haem iron from food. Free radical damage due to iron overload may be particularly acute in haemochromatosis when antioxidant status is low.[9]

Conclusions

Iron-deficiency anaemia is very common worldwide, particularly in women. However, although iron supplementation is commonly indicated for otherwise healthy people, it must be avoided in those genetically susceptible to haemochromatosis and iron overload. For most healthy individuals, the iron content of multinutrient formulas is perfectly safe. When diagnosed iron deficiency needs rectifying, a separate iron supplement should be swallowed two hours away from other supplements or meals to ensure effective absorption.

For further information on vitamins, minerals and supplements, visit the Health Supplements Information Service website at www.hsis.org

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Terms to guide use of iron

- RNI – The reference nutrient intake is the daily amount of a nutrient that is sufficient to meet the mean (average) requirements of a given population plus two standard deviations, that is 97.5 per cent of a given population.
- SUL – The safe upper level is the intake that can be consumed by an adult daily over a lifetime without significant risk to health.

Actionplan

1. Look through your supplements section. In your practice workbook note products containing more than 17mg iron as a daily dose. Are these designed specifically for pregnancy? When you sell them do you make any comment about nausea? Should you?
2. Do you think you should stop recommending/stocking the above unless they are for pregnant women?
3. What do you recommend OTC for clients asking for iron supplements? Do you question why they want these products? Record their reasons. After, say, 20 can you identify a common theme? In the light of the views expressed in this article, will you change your approach? What will you now recommend?
4. Look back on this series of articles on supplements. It would seem that, in general, people's intake of the vitamins and minerals described is below that recommended. Do you think this is correct? If so, are there significant effects, what are they, and what should we do about it?
5. Another common theme in these articles is that insufficient intake results in 'tiredness', increased risk of infection and other common minor symptoms. Is this correct in your opinion? If so, how should pharmacists alter the situation?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the August 6 issue, which will cover this week's CPP accredited module together with those in the July 9 and 30 issues. These will cover: **● Kidney dialysis and transplant (1342) ● Iron (1343) ● Indigestion part 1 (1344).**

A telephone marking service offers independent verification of results – details on the monthly MCQ paper. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

Paper supports use of trimethoprim for UTIs

Women benefit from trimethoprim treatment for urinary tract infection symptoms even if urine testing has proved negative, says a paper in this week's *BMJ*.

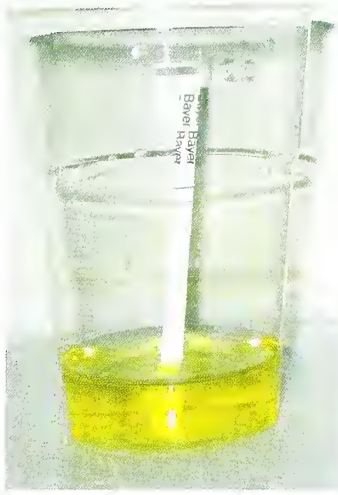
The New Zealand researchers say their findings support the empirical use of antibiotics guided by symptoms. Sixty six patients with uncomplicated UTI signs and a negative dipstick test for nitrites and leucocytes were randomised to receive either trimethoprim 300mg daily or placebo, and asked to keep symptom diaries for seven days.

The average time for resolution of dysuria was three days for the trimethoprim patients, compared to five days for those on placebo. Furthermore, 41 per cent of the placebo group were still suffering dysuria after seven days, compared to just 10 per cent of the treatment group.

However, the authors say more work is needed, as prescribing antibiotics for UTI symptoms regardless of dipstick results may result in superinfection, increased bacterial resistance and more adverse events. They conclude: "This further highlights the tension between relieving symptoms expeditiously with the desire to minimise unnecessary antibiotic use."

For more information:

BMJ 2005; 331:143-6



The dipstick urine test for UTIs

Midazolam better than diazepam for acute fits

Buccal midazolam has been found to be more effective than rectal diazepam for the emergency treatment of children with acute seizures.

Children aged six months and older who arrived having a fit at the casualty department of participating hospitals in Derby, Liverpool, Nottingham and Birmingham were given either buccal midazolam or rectal diazepam.

Therapeutic success was reported in 56 per cent of the 109 midazolam patients and 27 per cent of the 110 patients given diazepam, with no difference in the rate of respiratory depression.

Midazolam's speed of onset and duration of action support its emergency use in seizures, especially as rectal administration of drugs can be difficult in certain situations (eg schools) and absorption is variable, say the authors.

But in an accompanying article, a US paediatric neurologist calls for more work on calculating doses and out-of-hospital use to be conducted.

For more information:

Lancet 2005; 366: 205-210

NICE delays decision on Alzheimer's drugs

The National Institute for Health and Clinical Excellence has delayed publishing its final review of Alzheimer's drugs, saying it needs more information from the pharmaceutical industry.

In preliminary guidance issued in March, NICE said the high cost of donepezil, rivastigmine, memantine and galantamine outweighed the potential benefits of treatment (*C&D, March 12, p12*). But although it is standing by its original conclusion, the organisation is now saying that responses received during consultation suggested that the drugs may be particularly effective for certain patient groups, and has asked for supporting evidence.

NICE chief executive Andrew Dillon said: "We are acutely aware of our responsibility to people with Alzheimer's disease... we think there is more data which could affect our decision and we are asking the drug companies for access to it." Responses will be considered in October, he added.

Meanwhile, the organisation Action on Alzheimer's Drugs has been formed to demand access to AD medicines on the NHS.

For more information:

www.nice.org.uk

Scriptlines

Cozaar 28s

Merck Sharp & Dohme has launched a 28-day pack of Cozaar 25mg tablets (losartan potassium).

The company says the new pack size has been launched in response to "patient and physician demand for reduced packaging" and will replace the existing seven-day pack.

Price: 28 tablets £18.09

Pip code: 317-0347

Merck Sharp & Dohme Ltd

Tel: 01992 467272

Pepti out

Cow & Gate has introduced Pepti, a hydrolysed whey formula, to its range of baby milks.

Allowed on NHS prescription, Pepti is recommended for the treatment of cows' milk protein allergy, which affects 2-3 per cent of infants.

The company says the product has been launched following advice issued by the chief medical officer that said soya formulas should not be first choice for such patients due to the potential risk from their high phytoestrogen levels.

Pepti may be used from birth onwards and is well tolerated due to its 80-85 per cent short chain peptide and 15-20 per cent free amino acid content, according to Cow & Gate.

The company adds that the powder is also suitable for infants who cannot tolerate soya formulas, and has been shown to reduce the prevalence of eczema, inconsolable crying and infantile colic caused by allergy or intolerance.

Price: 900g £23.97

Pip code: 315-0307

Nutricia Ltd

Tel: 01225 768381

Legius dressings

A range of dressings containing 99.9 per cent charcoal has been launched by Benefoot UK.

Legius sterile dressings are non-absorbent, available in three sizes, and supplied in singles. The high activated charcoal content provides "superior odour control" and the manufacturer says the range is suitable for several types of wound.

Prices and pip codes: 10x10cm £1.60 317-0354, 10x20cm £2.18 317-0362, 15x25cm £3.50 317-0370

Benefoot UK Ltd

Tel: 0161 273 6789

Glutafin launch

Nutricia has launched Glutafin Shortbread, a new product that has been granted prescription status for gluten sensitive enteropathies.

In addition, the manufacturer has announced the de-listing of Glutafin Crisp Rolls, Glutafin Ginger Nut Cookies and Glutafin Shortcake. Chocolate Chip and Peanut Cookies have also been renamed Chocolate Chip Cookies.

Trade price: 100g £1.40 ex VAT

Pip code: 316-7848

Nutricia Dietary Care

Tel: 01225 711677

Azactam

All strengths of Azactam for injection (aztreonam) are currently in short supply, and are likely to remain so for several months, says Bristol-Myers Squibb.

The announcement affects the 500mg, 1g and 2g variants, though the company says it can provide it on an individual basis.

For more information, including supply requests, contact BMS Medical Information on tel: 0800 731 1736.

Pharma Nord

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Coenzyme Q10 is a vital nutrient with a very high antioxidant activity. It may help maintain:

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- Healthy gums
- A healthy immune system
- Healthy energy levels

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Professor Fred Crane, the American scientist who discovered coenzyme Q10 in 1957 recommends Bio-Quinone Q10 because of its superior bio-availability.

Bio-Quinone Q10 is the Q10 formula that provides the best absorption of the active ingredient in the human body.

Pharma Nord

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Name _____

Address _____

_____

Post Code _____

Pharma Nord (UK) Ltd, Telford Court, Morpeth, NE61 2DB

Bronnley for men

Bronnley has introduced its first men's grooming range, which has a fresh, coastal theme.

Called Bronnley Body Care for Men, the products have a clean, zesty fragrance and include notes of bergamot, lime and coriander on a base of amber and cedar. The toiletries are enriched with samphire, a moisturising and toning marine extract.

Products in the range include aftershave balm, soap, bath relaxant, deodorant stick, eau de toilette, hair & body wash and shaving cream.

The packaging features retro-styled coastal illustrations.

Prices: aftershave balm 200ml £6.95, bath soap 150g £4.95, bath relaxant 200ml £6.95, deodorant stick 75g £6.95, eau de toilette 100ml £14.95, hair & body wash 200ml £6.95, shaving cream 200ml £9.95

H Bronnley & Co Ltd
Tel: 01280 702291

Lux launches liquid hand wash

The Lux range has been extended with the launch of two variants of liquid hand wash. The product comes in the two best selling bath and shower fragrances, Heavenly Milk and Shimmering Sea.

Price: 250ml £1.69

Unilever UK Home & Personal Care
Tel: 020 8439 6100

Vitiven soothes heavy legs

Relief for heavy, tired legs comes in the form of new Vitiven Ultra Cold Massage Gel from Arkopharma. The plant extract formulation will help cool and soothe hot, tired and aching legs, claims the company.

The plant extracts used include red vine to increase blood circulation, butcher's broom to reduce swelling, witch hazel for its tonic action on veins, horse chestnut to strengthen capillaries, menthol and camphor. The gel is suitable for sensitive skin.

Price: 150ml £7.50

Pip code: 311 8817
Arkopharma UK Ltd
Tel: 020 8763 1414

Grisol AF 1% launched

Athlete's foot treatment Grisol AF 1% Spray Solution has been launched for topical application to the feet. The product contains griseofulvin 1%. It is made by Transdermal Ltd and is distributed by M & A Pharmachem.

Price: 20ml £5.99

Pip code: 299-0489
M & A Pharmachem Ltd
Tel: 01942 816184

Baby Softwash gets Extracare additions

The Johnson's Baby Softwash range has been enlarged with the addition of three Extracare products.

They include Extracare Creamy Bodywash, which contains baby oil; Extracare Bath, to lock in extra moisture, and Extracare Body Wash, with twice the amount of moisturisers than in regular Baby Softwash.

Price: Creamy bodywash 200ml £2.99, bath 250ml £2.29, 400ml £2.99, body wash 250ml £2.49, 400ml £3.49

Johnson & Johnson Ltd
Tel: 01628 822222

Fuji Professional adds new films

Fujifilm Professional has added two medium-speed colour negative films to its range. Fujicolor Pro 160S and Pro 160C feature smoother skin tone rendition, improved neutral grey balance, fine grain and wide exposure latitude (-1 to + 3 EV). Both films have been optimised for digital scanning.

The Fujicolor Pro 160S is ideal for wedding, portrait and fashion photography while Fujicolor Pro 160C offers higher contrast and more vivid colour, so it's suitable for a wide range of uses.

They will replace the existing Fujicolor Portrait Film NPS 160 and NPC 160. The new Pro 160S comes in 35mm, 120, 220, 4 x 5in, 8 x 10in and 4 x 5 Quickload formats while Pro 160C is available in 35mm, 120 and 220.

For more information:

Fuji Photo Film
Tel: 020 7586 5900

Johnson's eye make-up remover even tackles waterproof mascara

Johnson's has introduced a range of gentle make-up removers that it says will get rid of even waterproof mascara.

Gentle Eye Make Up Removal Pads contain a light lotion to gently remove all traces of eye make-up, including waterproof mascara, but without a greasy film.

Face and Eye Make Up Removing Wash is a transparent gel with soft blue pearls that break on contact with skin to release a natural oil that dissolves make-up.

Face and Eye Cleansing and Moisturising Lotion contains a mineral complex to remove make-up and leave skin fresh and moisturised for 24 hours.

Price: eye make up removal pads 30 £3.99, face and eye make up removing wash 150ml £3.99, face and eye cleansing and moisturising lotion 200ml £3.99

Johnson & Johnson Ltd
Tel: 01628 822222

Matron keeps hands clean

Matron, a new product that claims to kill the MRSA superbug without drying out hands, has been launched by KWL.

Available in balm mint and citrus lemon fragrances, the alcohol-based hand gel is said to be active against many types of bacteria, including MRSA, MSSA, *Salmonella*, *Pseudomonas* and *E coli*. The gel can be used without water and contains moisturisers and aloe vera to protect hands from the drying effects of alcohol.

The actress Lesley Ash, who contracted MSSA during a hospital stay, was involved in Matron's development. As part of her involvement with the Patients' Association, she has called for better standards of cleanliness in hospitals, but said: "Patients need to take personal responsibility, and this is a small start."

KWL managing director Ken Wells said the range would be extended in the future, and would be supported by a "major advertising campaign". He added: "We believe it is a major weapon in the public's war against superbugs."

Matron is currently only available in supermarkets, but a company spokeswoman said the product would be launched to pharmacies via wholesalers in August or September.

Price: 200ml £3.99

KWL
Tel: 01344 390555

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Ceuta Healthcare, tel: 01202 780558
www.dextroenergy.co.uk

TV

Bisodol: Sat

Buscopan IBS Relief: GMTV, Sat

Canesten AF: C

Germoloids: C4, five, GMTV, Sat

Lanacane: All areas

Rennie: All areas except CTV, CAR

TENA Lady: All areas except U, CTV, LWT, GMTV

TENA Pants Discreet: All areas except U, CTV, LWT, GMTV

Zovirax Cold Sore Cream: C4, five, Sat

PharmaSite for next week: Zovirax – Window, **Mycota –** In-store, **Refresh eye drops –** Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Seeing the **bigger** picture

As community pharmacy goes through its biggest contractual upheaval for a generation, Neal Patel of the NPA looks at how other NHS changes may affect the healthcare landscape

New forces are converging on the NHS. Some seem entirely nebulous, like the changes in contracting and commissioning, while others are entirely tangible, such as the introduction of contestability. This is a nice way of describing competition which itself is a way of delivering choice. Interesting, but relevant to pharmacy? Absolutely. In some ways many of the changes in the NHS are familiar to community pharmacy.

A cull of the big beasts

So what is happening in the NHS and what comparisons can be drawn with community pharmacy? Let's start with the big beasts of the NHS – GP practices and hospitals. Both have enjoyed a virtual monopoly on primary and secondary care provision which now doesn't suit the aforementioned choice and contestability agenda.

Previously hospitals were funded through contractual arrangements with PCTs, so-called 'block contracts', which were unrelated to activity. This guaranteed income but was seen by many to offer no incentive for hospitals to improve services or offer greater value for money. The solution is seen to be a mechanism for paying hospitals according to the activity they undertake. This has been termed 'payment by results' or PbR. To avoid the competition on price seen in the 'internal market' in the early 1990s this is accompanied by a national tariff, which sets a price for each episode of elective care or operation.

Now hospitals are paid according to the quantity of operations they perform, with the money following the patient. The same price is paid by the PCT regardless of where the operation is performed, thus avoiding competition on price. However, hospitals that are able to operate (quite literally) below tariff prices will be able to invest savings in improved services.

Foundation hospital trusts will be given partial independence, allowing them to borrow in order to invest, rather like independent businesses. This step change in contracting arrangements means the newly formed foundation hospital trusts and new, privately owned, independent sector treatment centres will have to be attractive to commissioners if they are to remain in the black. The acid test for this policy is whether it will be politically acceptable for a local hospital to fail financially and close?

Financial catastrophe aside, the system now includes another incentive to drive up quality and reduce waiting times – choice. By the end of this year all patients will be offered a choice of five hospitals when they require elective surgery and, by 2008, they can choose any provider deemed appropriate by the healthcare commission – private or NHS. However, the fact that hospitals are expensive places to receive care is well recognised by Government and now with an incentive to increase income through payment by results, hospitals could vacuum up a huge amount of NHS resource, so an effective counterbalance is needed.

The national tariff for elective care combined with allowing efficient hospitals to keep savings for investment may draw an interesting comparison between the community pharmacy *Drug Tariff* and the profit on purchase savings that are still allowed within the new community pharmacy contractual framework. However, more interesting changes in the NHS for community pharmacy are occurring at the other end of this process – the commissioning end.

Counterbalance

This brings us to the other ethereal change in the NHS – practice-based commissioning or PBC. Simplistically and in financial terms, if the NHS was a bank then, at the moment, GPs have blank cheque books.

With a national tariff for elective care and PbR, GPs can fill in the stubs as they refer patients, but what incentive do they have for checking the balance at the end of each month? In the main, it is GPs who refer patients to hospitals and make decisions about onward patient care with, it is perceived, little incentive to think about alternative routes of care. Practice based commissioning empowers GPs to make decisions about where and how patient care occurs and to invest any savings in improving premises, increasing staff, and, hopefully, improving services. For GPs, checking the NHS bank balance suddenly becomes a whole lot more interesting. This gives GPs a real incentive to redesign primary care services and shift work from acute hospital trusts into primary care. Fortunately, primary care is where community pharmacy sits.

Service redesign

As providers of healthcare services, pharmacists must be included in the discussions around service redesign, at best in locality groups, and at the very least on professional executive committees.

Commissioners need to be reminded of community pharmacy's unique selling point when it comes to healthcare provision compared to other venues – healthy people as well as sick people visit pharmacies. The community pharmacy network is unmatched in being able to boast readiness to deliver public health services and to offer screening to people who don't traditionally engage with the NHS. As the gap in health inequalities becomes larger, community pharmacy may offer a way of reaching communities that other parts of the NHS do not, or cannot reach.

Service development opportunities abound – just within the public health agenda there's smoking cessation, sexual health services including provision of emergency hormonal contraception and screening for STIs such as chlamydia. There are also weight management

services, and services to minimise the harm of substance misuse such as needle exchange and the supervision of methadone consumption.

By applying the reduction in health inequality test to any of these services, the logical place to commission them is community pharmacies, especially those pharmacies situated in disadvantaged communities.

Pharmacy engagement

PCTs' positive experiences of working with professional executive committee pharmacists should pave the way for active consultation with pharmacists. As local healthcare providers, the expertise and local knowledge of community pharmacists will be invaluable when looking at effective service redesign solutions. Could pharmacists hold indicative NHS budgets and could we see pharmacy based commissioning?

For that to happen two things need to be true. Firstly, pharmacists need to take on roles that allow them to make decisions about patient care which have a financial impact on the NHS. If introduced, independent prescribing will provide one opportunity here. Secondly, pharmacists need to be involved in patient referral. Enhanced services – which empower pharmacists to take on case loads and make decisions about onward care – is one way this could happen. The doors may then open to pharmacy based commissioning – PhBC.

Are we heading in this direction? Service models and Government policy are certainly in place. The final piece of the jigsaw is achieving true pharmaceutical clinical leadership and investment in the postgraduate development of the profession; skills and services will need to develop in tandem. However, it's also true that the development of practice based commissioning involving pharmacy may happen insidiously. We are already seeing community pharmacists taking on the role of partner within GP practices and with the shortage of GPs being likely to become more acute, the make-up of a traditional primary care practice will look very different in the future.

Choice in primary care

But there is another even bigger change on the horizon: choice in primary care. Registration of patients with GPs is attractive in terms of continuity of care – but if you're away from home and require medical help it becomes a barrier. This barrier may come down soon.

Resource pack

The NPA's NHS Service Development team has been following carefully the emergence of new commissioning models and considering potential opportunities for community pharmacists.

To support members it has produced a resource pack entitled, *Commissioning: a resource to support pharmacists in understanding the key commissioning routes for primary care services in England*. This resource will provide the information and understanding required to help ensure that community pharmacists become leaders in breaking down barriers and will lead the way in service redesign.

Opportunities for community pharmacists

Community pharmacists have the opportunity to become involved with their PCTs and others locally, via the commissioning process, to identify the solutions and services that are required to meet local needs.

The PCT now has a wide range of flexible contracting options with which to contract for locally tailored services. This means that potential providers (including community pharmacists) should not be restricted to providing services in accordance with traditional boundaries. This opens up the opportunity for community pharmacists to consider becoming involved in providing almost any healthcare service in primary care – as long as the service redesign proposal they put forward meets local patient needs, can be delivered to meet the appropriate standards and quality, and will provide value for money.

The opportunities available to community pharmacists will be restricted only by the extent of their entrepreneurialism.

If pharmacy truly wants to enter into the arena of primary care service provision then the alternative provider of medical services (APMS) contract offers the option for a commercial contractor to provide medical services to a population. Traditionally used to fill gaps such as out-of-hours services, this commissioning route offers an attractive pick and mix option for the PCT – especially where current services fall below the expectation of patients. And in the new NHS the patient will increasingly dictate the range and type of services available. This is certainly an opportunity for community pharmacy. The combination of value for money, quality and patient-led service provision play directly into the profession's strengths and should mean more doors opening.

The doors may then open to pharmacy-based commissioning

Converging agendas

Again the alignment of the new contract with some national policy priorities can only be good news for community pharmacy – think of repeat dispensing not exclusively as a supply function but as the management of patients with long-term conditions.

Pharmacists have a role which starts with the prevention of long-term conditions (eg smoking cessation/health promotion) and the early detection of long-term conditions (eg diabetes/COPD screening). Pharmacists can also help with the prevention of crises through effective medicines management and prompt intervention.

Finally, pharmacists can assist with the care of patients with complex conditions through close support brought about by repeat dispensing. By pharmacists acting as referral points and also making referrals, patients with minor ailments will be treated in the most appropriate setting and patients with long-term conditions will be empowered to make decisions about their care in partnership with the pharmacist.

The new pharmacy contract offers an ideal platform for integrating community pharmacy into the PCT's strategy for managing long-term conditions and self-care.

The benefits of using community pharmacy in the management of patients with long-term conditions are clear:

- Patients are identified sooner – pharmacists can screen for diseases such as diabetes or high cholesterol or COPD.
- Patients are treated nearer to home – pharmacies are in the heart of communities.
- Patients are treated sooner – pharmacies are open weekends and some offer extended hours so patients have quick access to advice and treatment. This will potentially reduce the number of crises.
- Patients can self-refer to pharmacy and engage in self-care. This promotes independence, empowers patients and allows them to take control of their lives.

However, the commissioning processes discussed here do present risk as well as opportunity. Professional barriers are being broken down, challenging questions will be asked: who can do it best rather than who has done this before? This may undermine the highly protected and exclusive medicine supply function of the profession. As the medicine experts, retaining this within pharmacy will be imperative for us.

The opportunity, though, is to show that pharmacy believes its own hype. We have got the ability to offer better access and to provide a choice in primary care provision. The mix of public and private partnership, often the stumbling block to true NHS engagement, is now in fashion. With an entrepreneurial spirit community pharmacy has always been able to meet patient care in a responsive way.

The stage is set for pharmaceutical renaissance.

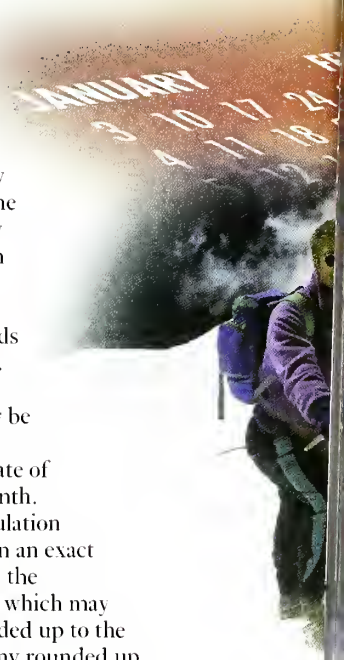
A plan for action

Community pharmacists need to ensure that their PCT begins to consider the opportunities available to commission community pharmacy services using alternative contracting routes, or, for community pharmacist contractors to lead multidisciplinary teams to provide new models of primary medical service provision. They also need to ensure that their PCT includes community pharmacy in its commissioning processes, especially in the planning stage.

If pharmacists are not proactive in [illegible] their PCTs and maximising the potential opportunities there is a risk that pharmacy could be marginalised or even adversely impacted.

Holiday rights

Gareth Edwards and Michelle Chamberlain set out an employers' guide to workers' holiday rights



Perhaps surprisingly, the legal right to paid holiday has only existed since 1998. The *Working Time Regulations 1998* introduced a statutory right to four weeks' paid leave in each leave year.

The principle is simple, but as usual putting it into practice is never quite as straightforward. What about those workers who start work part-way through a holiday year? What entitlement do part-timers have? Can employers recover holiday overpayments from a worker's final pay cheque?

Q What is a worker's basic right to holiday?

A By law, a worker is entitled to four weeks' paid annual leave (known as 'statutory leave'). This is a minimum entitlement. A worker may have a greater entitlement under his contract of employment (known as 'contractual leave'). One type of leave is set off against the other, so statutory leave is usually counted within any contractual leave entitlement.

Q Does statutory leave include public holidays?

A In England and Wales, there are usually eight bank or public holidays each year. Under the regulations, the right to four weeks' leave is not additional to public holidays. Therefore, public holidays can be included as part of a worker's statutory annual leave entitlement. As part of its election campaign, Labour pledged to ensure that public holidays would be given in addition to the four weeks' statutory leave, if it secured a third term in government. No legislation has yet been proposed but employers should be aware that in future public holidays may well be granted in addition to the four weeks' statutory leave.

Q Who is entitled to statutory holiday leave?

A The regulations apply not just to 'employees' but to a wider category of 'workers'. However, the genuinely self-employed are excluded. As a general rule, a person is a 'worker' for the purposes of the regulations, if he is someone who is paid a regular wage or salary and works for an organisation, business or individual. The employer normally provides the worker with work, controls when and how the work is done, supplies him with tools and other equipment, and pays tax and National Insurance contributions. However, these are only general guidelines and each case must be looked at individually.

Q Does the law prescribe when a holiday leave year begins?

A A holiday leave year can start on any date in the year agreed between the worker and employer. It is usually specified in the contract of employment or employer's handbook. If there is no such agreement, the holiday year will begin on October 1, 1998 (and subsequent anniversaries) for those who started work on or before that date. If the worker commenced employment after October 1, 1998, then the holiday leave year will start on the date the worker started work for the employer.

Q What about part-time workers?

A Part-time workers should have an appropriate pro-rata entitlement to holiday. For example, a person working three days a week would be entitled to 12 days' paid statutory annual leave. Equally, if a full-timer gets paid for bank holidays in addition to their statutory leave, then part-timers are entitled to a pro-rata entitlement.

Q What happens when a worker starts work part-way through a holiday leave year?

A Where a worker begins work after the start of the employer's holiday leave year, the worker's holiday entitlement will be proportionate to the amount of the leave year remaining (ie a pro-rata entitlement). For example, if the holiday year runs from January to December and a new employee starts on August 1, his entitlement is 5/12ths of the leave year. Where such a leave period includes a proportion of a week, the proportion is to be determined in days and a fraction of a day will be rounded up to count as a whole day.

Q What if a worker leaves before the end of the leave year?

A Similarly their annual leave entitlement is pro-rated to the proportion of the leave year that they have worked.

Q Is there a period of eligibility before a worker is entitled to take leave?

A A worker's entitlement to paid statutory annual leave begins on the first day of employment. Only workers in their first year of employment are said to 'accrue' their statutory holiday leave. All other workers, subject to giving appropriate notice, can take leave at any point in the holiday year without first having to 'accrue' it. During the first year of employment, an employer can use an accrual system, whereby the portion of the leave which may actually be taken (with the employer's agreement) builds up over the year. The amount of leave which may be taken accrues in advance at the rate of 1/12th each month. Where this calculation does not result in an exact number of days, the amount of leave which may be taken is rounded up to the next half day. Any rounded up element is deducted from the leave remaining.

Q What is a week's leave?

A A week's leave should allow the worker to be away from work for a week. So it is the same length of time as they work in a normal week.

Q When can leave be taken?

A The regulations allow employers and workers to agree their own arrangements for taking leave. They are usually provided for in the contract or other company documentation. In the absence of any agreed procedure, the regulations provide that a worker may be required to take all or any of their leave under the regulations at specified times provided that prior notice is given by the employer. The notice from the employer should be at least twice as many days as the number of days' leave to be taken.

Under the regulations, a worker can also give notice of when they wish to take leave. Again, the notice period should be at least twice the period of the leave to be taken. The employer may refuse the worker permission to take such leave. To do so, the employer must give notice equal to the number of days' leave requested. In practice it seems preferable to agree longer and more workable arrangements.

Q Can leave be carried over to the next holiday leave year?

A Statutory leave cannot be carried over to the next leave year. It must be taken in the current leave year. So for example, leave for a

holiday year commencing January 1, 2005 must be taken before December 31, 2005. Employers can make separate arrangements to carry over contractual leave in excess of the statutory minimum, if they wish to do so. Where carry over of contractual holiday entitlement is allowed, employers will generally impose a time limit on when the carried over leave should be taken, for example within three months of the end of the holiday year.

Q What about those on long-term sick leave?

A Previously, case law interpreted the regulations as not imposing any obligation on a worker actually to perform work or be present at work in order to be eligible to receive paid annual leave. Therefore, workers on long-term sick leave were entitled to take four weeks' statutory holiday pay, where they had given appropriate notice to their employer. However, this approach was recently overruled by the Court of Appeal.

Now, if a worker has not attended work throughout the holiday year because of long-term ill-health and has exhausted their entitlement to sick pay, then they have no entitlement to claim holiday pay under the regulations. This clearly leaves some uncertainty as to what is the position with regard to those who are absent for a proportion, but not the whole of the holiday year.

A logical solution may be to take into account the amount of time worked during the holiday year and to pro-rate the holiday entitlement accordingly. The current law, however, leaves it open to a worker to argue that attending work at some point during the holiday year means they continue to accrue their full entitlement to statutory holiday. The issue is likely to be appealed and until it is, there is no clear guidance.

Q How do you calculate a week's pay?

A Workers are entitled to receive a week's pay for each week's leave. For those with normal working hours (ie the number of hours fixed by their contract), a week's pay is the amount that they would earn for a normal working week. Overtime, unless it is contractually guaranteed overtime, is not included. Commission payments may also be excluded from holiday pay calculations, depending upon how the employee's remuneration is structured.

If a worker does not have normal working hours, a week's pay is calculated by reference to his average pay over a 12-week period. A worker's contract may allow for more generous holiday payments.

Q What about rolling up holiday pay into basic salary?

A There has been much debate in the courts about whether the practice used by some employers of rolling up holiday pay into workers' hourly or weekly rates of pay is lawful.

Such 'rolled up' arrangements are commonly used for administrative convenience in particular industry sectors where the workforce may be transient or operate on a shift system. The matter has been referred to the European Court of Justice for definitive guidance, although a decision is not expected until late 2005 or early 2006.

In the meantime, if employers wish to use this kind of arrangement, they should ensure that it complies with recent court guidance on rolled up holiday pay. In essence, any rolled up holiday pay arrangement must ensure that there is mutual agreement between the worker and employer for genuine payment for holidays, which represents a true addition to the contractual rate of pay for the time worked.

Q Can employers make payments in lieu of untaken holiday?

A An employer cannot pay a worker in lieu of holiday entitlement under the regulations unless the worker's employment is terminated. This does not, however, prevent employers and workers from agreeing to a payment in lieu for untaken contractual holiday entitlement over and above the four week entitlement provided for in the regulations.

Q How do you calculate holiday pay on termination of employment?

A The Regulations set out how to calculate a payment in lieu of accrued but untaken statutory holiday, when the worker's employment ends. This formula will apply if there is no other agreement between the worker and employer on how such a payment should be calculated. The statutory formula basically deducts the worker's entitlement from the amount of leave he has already taken.

For example, if a worker works five days per week and terminates their employment six months into the leave year having taken six days leave, the entitlement would be to a sum equivalent to: (20 days x 0.5) – 6 = 4 days' leave. The worker would therefore be entitled to four days' payment in lieu.

An employer cannot provide in the contract that no payment in lieu of accrued statutory holiday will be made. However, in certain circumstances (eg dismissal for gross misconduct) it may be acceptable to allow for token payment. The amount of holiday a worker has accrued should be calculated on the basis of the number of working days and not calendar days in the year.

Q Can an employer recover holiday overpayments?

A If a worker has taken more holiday during the leave year than he has accrued up to his termination date, then employers often deduct such payments from the final pay cheque. An employer will only be able to do this where there is an agreement between the worker and employer to do so. Such a provision is often included in the contract of employment. Employers should take note that in the absence of such an agreement, no deduction can be made.

Q What are a worker's remedy?

A Under the regulations, the right to paid holiday is enforced through employment tribunals. Usually, complaints must be presented within three months of the date on which it is alleged that the leave should have been begun. Where a complaint is upheld, the tribunal will make a declaration to that effect and may award compensation to the [illegible]

Gareth Edwards is an associate solicitor and Michelle Chamberlain is a practice support lawyer in the Eversheds Human Resources Group.

We all remember Boxing Day 2004 for the devastating tsunami in the Indian Ocean which killed thousands. Alyson Wright, a pharmacist with Alliance Pharmacy, went to Sri Lanka to help with the relief effort. Six months on she shares her story

With a little help from my **friends**

On Monday May 16, I returned to Sri Lanka to continue the work I started with Project Galle 2005, which was set up just after the Boxing Day tsunami by expats living in the area. Making my way down the west coast to the city of Galle, I was struck by how much has changed.

Most of the tents have now gone and temporary houses replace them, beaches are once again filled with fishing boats, and street vendors line the side of the road. But I soon learned that it was not all as positive as it seemed. Money is still slow to arrive from the government and most families are living in small one-roomed wooden houses, which have become more long-term than intended. These camps are suffering drainage problems, and the 100m rule means that houses cannot be rebuilt if they are within 100m of the shore, leaving many families homeless.

New volunteers had arrived in my absence and yet some old faces remained, but the spirit had grown and friendships had developed further.

My 'official' role was PA to the management at the project – I had the advantage of having been there before and knowing the management and how the project worked. I also got involved in many of the field activities, including completing a few drainage surveys (assessing camps for problems) and the final medical pack drop the project would make. Accounts, stock-taking and general personnel also made up part of my role.

I had to do something for the tsunami victims after being moved to tears watching reports

The most memorable and fulfilling job for me was getting involved in the Livelihoods Project, which tried to rebuild people's lives after they lost their jobs or the equipment they needed to work after the tsunami.

I first decided I had to do something for the tsunami victims after being moved to tears watching reports from the areas affected. I received e-mails from Roger Cotton, a senior manager at Fern House (our head office), informing our team of the branch collection boxes and the donations that UniChem had made, but I was compelled to do more. I e-mailed Roger about the possibility of organising extra fundraising or travelling out to the area and from this point on everything happened in a blur. Roger put me in contact with another employee who also approached him about travelling out to help the local people in Sri Lanka.

Plans began to come together and four of us set off at the beginning of February – a pharmacy assistant, two engineers and myself. We had no idea what we were going to do but we were told to expect the worst.

We spent our first few days in February in a place called Kalutara, which is on the west coast, helping to clear land for houses and doing general tasks before moving on to Galle. We were shocked at the lack of well-known organisations in the area, particularly as we knew how much money the public had donated, but encouraged that this small organisation had grown so much, providing food and aid to over 70 camps in the region.

Pharmacy work was kept to a minimum – they had hundreds of their own medics, pharmacists and nurses, and for the most part, basic first aid was as far as my pharmacy skills went. However, we did provide every family on the project's books with a family first aid kit, including basic medicines for the children. We were all busy working in offices, kitchens, warehouses and fields and the dedication of the volunteers was amazing.

We were struck by the number of people who were receiving no aid from the government – despite media reports to the contrary. But just by being there and working with the project, we were making a difference. Seeing the smile on children's faces as you handed them a cricket or tennis ball, or the tears in a man's eyes as you gave him a bag of rice, made every second worth it.

I was humbled so much by the thousands of people affected by the tsunami. They had lost members of their families, their homes, their jobs, yet they could still smile and say thank you. It brought home to each of us how much we have at home – and how little these people have been left with.

Many people ask me what the hardest part of being there was. Was it living in a tent with a hole in the ground as my toilet and a well for washing? Was it seeing the devastation? I can honestly say it was getting back on the plane to come home. We saw housing projects begun and education projects in the pipeline but we had tears in our eyes knowing that we were leaving with so much work still to be done.

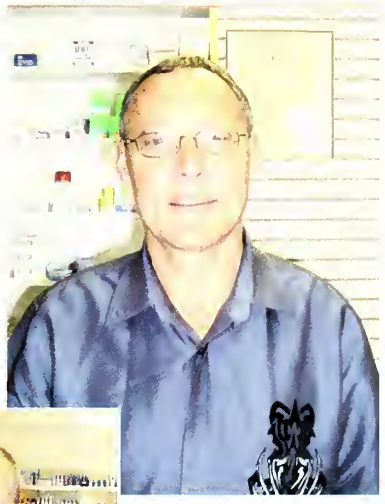
There were three unofficial tsunami warnings in the month I was there and I experienced the fear people have of another such disaster. It was heartbreaking to watch the panic and not be able to help, but comforting to know that a system was now in place to evacuate the area.

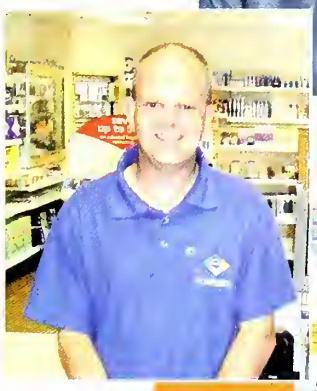
I have many Sri Lankan friends now – and have heard their experiences and their fears many times over. So much has still to be done, and yet the media have forgotten. It was hard to leave the first time – but worse the second, and for that reason I will go back in October.

I am so grateful that Alliance Pharmacy has allowed me time off work to travel again, and that it has been so supportive. It has been an amazing and life-changing experience and I am looking forward to being able to tell you all what a difference has been made in the past few months in Sri Lanka.

Learn everything you possibly can

Co-operative Group Pharmacy is dedicated to providing the highest standard of healthcare to local communities. Jane Ellis reports





Top to bottom: Ron Law, Andrew Watson and Kate Robinson

While Co-operative Group Pharmacy was in the process of registration in 1945, the Co-operative Wholesale Society (CWS) sent out a circular inviting independent retail societies to set up a national network of co-operative pharmacies.

More than 50 years on, Co-operative Group Pharmacy has 355 branches spread from Plymouth to Thurso in Scotland, taking in Wales and Northern Ireland on the way.

The company is dedicated to providing the highest standard of healthcare to local communities. Its aim is to continually improve the range and quality of services provided. It currently employs 380 full-time pharmacists. Total turnover is more than £200m per annum and the pharmacy group dispenses more than 15 million prescriptions each year.

Co-operative Group Pharmacy HR manager Ron Law says its pharmacists need to be ambitious and customer-centred. They are encouraged to develop their potential and grow from being a branch manager into tackling a bigger, more challenging branch and then perhaps progressing into a 'cluster' leadership role, managing a group of stores.

There are also opportunities to develop a career within the operational field structure as a retail manager, responsible for marketing and merchandising standards and compliance in branches, or pharmacy services manager, responsible for developing relationships with PCTs and other healthcare bodies.

> "[Pharmacists] are encouraged to be active in pursuing opportunities within PCTs and at LPC level"

The company is also busy developing new roles to meet the needs of its own business strategy and the challenges of the new pharmacy contract.

Co-operative Group Pharmacy has achieved Investor in People status and all of its pharmacists have a personal development plan, which they follow through with self-learning CPD.

"We feel it is critical to our business success for our pharmacists to play a key role in providing services to our customers," says Mr Law. "Working alongside our pharmacy services managers, they are encouraged to be active in pursuing opportunities within PCTs and at LPC level."

Basic salaries are said to be excellent with bonus schemes linking performance against a branch scorecard. Other benefits include a final salary pension scheme, five weeks' holiday, discounted BUPA healthcare, life assurance, insurance and financial advice.

In addition, after completing the initial three months, pharmacists will receive a discount card for Co-operative Group businesses.

Co-op pharmacists are given the freedom to openly share their views about how the business is doing and make suggestions about how it can improve.

"We believe in behaving with honesty and integrity in everything we do and we aim to treat people with equal respect," says Mr Law.

Such ethics mean that staff retention is high. Team members who demonstrate that they have acted on these values and given great service are rewarded and appreciated through the 'Little Diamonds' colleague recognition scheme.

"Most of all we listen and involve our colleagues in decisions about the business through annual census surveys and 'let's do it better' focus group sessions. This all adds up to a great place to work," says Mr Law.

Staff are actively encouraged to move and try out new roles through internal succession planning and short-term projects and secondments to enhance skills for colleagues within the branch network.

Stefan Fec, for example, was a pharmacist branch manager in Wales who expressed a desire to get involved in field activities and is currently on secondment as an acquisitions manager working on the integration of newly acquired businesses.

Kate Robinson became cluster leader late last year, taking on this dual role to support fellow pharmacists and branch teams. She has now been offered a secondment as relief regional sector manager taking on a field management role for more than 20 branches.

EPoS training officer Andrew Watson joined the group in 1990, bringing with him experience as a camera salesman at Cecil Jacobs in Leicester. For the next four years he established and maintained a busy photographic department at the Co-op's branch in Corby, before being promoted to shop supervisor. At the same time, Mr Watson was following a pharmacy assistant education programme, completing the NVQ in pharmacy services Level 3 last year.

He was later seconded to Kettering, helping with the dispensing of drugs to 10 nursing homes and managing the delivery and collection of prescriptions from surgeries and homes. He also helped out at other branches on shop refits and staff training. Most recently he has applied to become a permanent training officer on the recommendation of Mr Law.

"The company is always willing to offer you different jobs and give you experience," says Mr Watson. "And I've always been willing to go off and do anything they've asked me to do." In spite of this, he maintains that he does not like change. However, he is philosophical about it. "You can't stop progress, so you might as well go with it and learn everything you possibly can. I've been very happy with the company and feel I'm well thought of."

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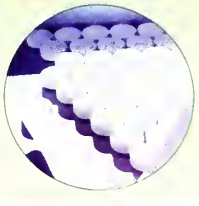
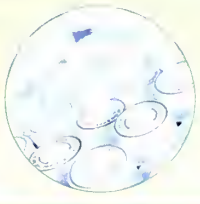
I would ask all my colleagues to review their professional advisers and if in any doubt – just get out. You will save yourselves a lot of headache. This is my personal view of course.

I highly recommend Modiplus. A very friendly and a helpful team of people.

Mr A Singh, Midlands





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Mystery of the appearing book

UK pharmacists lamenting the summer sales lull could take note of a new US strategy to drum up some much-needed trade.

A customer at Eckerd Pharmacy in New York recently found herself one of the first people in the world to read *Harry Potter and the Half-Blood Prince*, after embargoed copies of the book appeared on the shelf.

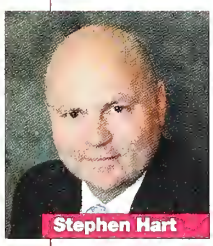
Mandy Muldoon, a customer at the pharmacy, bought one for her stepson, not realising that the book did not officially appear until midnight last Saturday.

This is the second time the new Harry Potter book has materialised on retailers shelves. A gag order was issued in Canada after 14 copies were inadvertently sold at a supermarket near Vancouver.

Eckerd Pharmacy customer Ms Muldoon said she would return the book to the publisher, although her stepson had admitted reading two pages.

Lloydspharmacy buyer Chris Hawthorn shaved 1.29 minutes off his previous best time of 40.31m in the British 10km London Run. Part of the 85-strong Radian B team, he attributes his success to a pre-race massage from sponsor Radian B. The team included staff, suppliers and agencies of William Ransom & Son, as well as Olympic medal winners Helen Reeves and Bryan Steel. They raised around £5,000 for the Muscular Dystrophy campaign

Appointment



Stephen Hart

The community-based home healthcare provider Clinovia has appointed **Stephen Hart** as medicines management director. Mr Hart has a background in the pharmaceutical industry, having worked in marketing, customer services, logistics and project management roles. This grounding will serve him well at Clinovia, where he will be concerned with developing the company's medicines management portfolio.

Gillian Hawksworth

Congratulations to **Gillian Hawksworth** who has been awarded an honorary doctorate of science by the University of Bradford. Dr Hawksworth has been recognised for her contribution to the profession, her term as Royal Pharmaceutical Society president, and the support she has given to the university in promoting it as an education provider for pharmacists.

New at the National Pharmacy Association is **Billy Templeton**, who has joined as NHS service development manager for Scotland. Mr Templeton has worked in community pharmacy in Scotland for over 20 years and, until recently, held the post of community pharmacy adviser for East Ayrshire community health partnership.

Tesco has announced the appointment of **Carol Clarkin** as pharmacy services manager. With previous experience as a pharmacist and medicines buyer for Safeway, at Tesco Ms Clarkin will be responsible for delivering the new pharmacy contract to stores and developing private pharmacy services.

eBay opportunity

Thinking of buying a pharmacy? Then why not try *eBay.com*? The US version of the online auction house is selling the Olmos Pharmacy, an iconic local landmark famed for its soda fountain and thick, creamy shakes in San Antonio in Texas.

For almost 70 years, the Olmos has served cherry cokes and thick, frosty malts from its taps, although it also offers a full service professional pharmacy.

John Dodd has owned the pharmacy for 13 years but is looking for a young pharmacist who can handle the hours and the 'buy it now' price of $500,000. This does not include the building, which is available under a long-term lease.

There are also conditions, notably that counter-queen Betty Garza, who has been at the pharmacy for the past 35 years, stays just where she is.

Towering success

UK pharmaceutical distributor Lexon UK recently celebrated 10 years in business by holding a business partners' family fun day at Alton Towers.

Over 2,500 pharmacists and their families went along to the theme park which also hosted a trade show. From its beginnings as a 'shop above a shop', the distributor now boasts 1,100 customers a day, says director Anup Sodha.

Oshwal pharmacists recently walked 10km in 33 degree heat to raise an impressive £13,005 for charities including the Arthritis Campaign, the Stroke Association and the Oshwal Association UK. Some 90 members, including pharmacists, their families and friends completed the circular walk, which started at the Oshwal centre in Potter's Bar. The money raised for the Oshwal Association will go towards the building of a Jain Temple at the Potter's Bar centre

The knowledge

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Each assistant must be registered for telephone marking and certification at a cost of £41.13. Each assistant will also need access to a training pack. A pack costs £29.38 and can be used by up to four assistants.

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PRODUCT INFORMATION: NUROFEN FOR CHILDREN: Suspension of ibuprofen 100mg/5ml. **Indications:** reduction of fever, and relief of mild to moderate pain. **Dosage:** 20–30mg/kg bodyweight in divided doses (see pack for details). Not suitable for children under 3 months of age unless advised by a doctor. For oral administration. For short term use only. **Contraindications:** Hypersensitivity to constituents. History of, or existing peptic ulceration. History of asthma, rhinitis or urticaria associated with aspirin or other NSAIDs. **Precautions and Warnings:** If symptoms persist for more than 3 days, consult a doctor. Do not exceed the stated dose. Caution in patients with renal, cardiac or hepatic impairment. Asthma sufferers, anyone allergic to aspirin, receiving any other regular treatment and pregnant women should consult a doctor before use. Nurofen for Children is not suitable for patients with stomach ulcers or other stomach disorders. **Side Effects:** Hypersensitivity reactions including (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritus, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects may include abdominal pain, nausea, dyspepsia and gastrointestinal bleeding and peptic ulceration, renal failure. Also very rarely thrombocytopenia. Bronchospasm may occur in patients with a history of aspirin sensitive asthma. **Product Licence Holder:** Crookes Healthcare Ltd, NG2 3AA.

Legal Category: P. **MRRP:** 100ml: £3.59. 150ml: £4.59
Nurofen for Children: PL 00327/0085.
Date of preparation: June 2005.

References:

1. Sidler *et al.* A double-blind comparison of ibuprofen and paracetamol in juvenile pyrexia. *Br J Clin Pract* 1990; **44**(suppl70):22–25.
2. Kelley MT *et al. Clin Pharmacol Ther* 1992; **52**:181–189

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